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February 28, 2024

MEMORANDUM

MEMO NO.
QI-2406

TO: QUEST Integration Health Plans

FROM: Judy Mohr Peterson, PhD JMP
Med-QUEST Division Administrator

SUBJECT: REVISIONS TO THE HEALTH FUNCTIONAL ASSESSMENT (HFA) AND HEALTH ACTION PLAN (HAP)

This memorandum informs the health plans of revisions to the content, format, and arrangement of the HFA and HAP forms and attachments, Personal Assistance Tool, Skilled Nursing Tool, and instructions. The revisions were made to align and conform with regulatory and evaluation requirements, and in response to feedback from health plans and other stakeholders. Health plans are required to use the new version of these documents effective August 23, 2024.

Significant revisions include:

A. In all the documents:
    1. Adding Member's name, Medicaid ID number, HFA or Assessment Date on every page.
    2. Updating terminologies to align with the current, updated contract, i.e., service coordinator to health coordinator, service plan to health action plan.

3. Adding options to indicate that an assessment item is not applicable to the member, or the member declined to answer/participate.

B. HFA:
   1. Adding Expanded Health Care Needs (EHCN) in the population type section.
   2. Removing assessment items that are only gathered once and update is not needed, e.g., birth history and developmental milestones.
   3. Adding a "Table of Contents".
   4. Adding prompts in each section to indicate required completion of the sections for specific population types.
   5. Adding drop-down list or converting multiple check box options to drop-down list.
   6. Adding assessment questions and options that gather and identify specific details to:
      a. Capture potential care needs, safety risks, and other issues, e.g., emergency plans, reasons for emergency room visits and/or hospitalizations, COVID-19 vaccination status, and housing status.
      b. Capture member's preferences and existing support services, e.g., name and contact information of different individuals who are involved in member's care (i.e., interpreter, representative payee) and gender identity.
      c. Incorporate the Home and Community-Based Services (HCBS) Settings Final Rule requirements, e.g., use of restraints and access to food and setting.
   7. Re-arranging different sections, separating clinical and non-clinical information, and adding a new section to document verification of completion and attestation of the licensed staff reviewing and validating the entire assessment to align with the cohort approach, a process of completing the HFA.

C. HFA attachments
   1. Replacing the attachment for Substance Use with the Tobacco and/or Cut, Annoyed, Guilty, & Eye-opener screener – Adapted to Include Drugs [CAGE-AID] to align with Alcohol and Drug Abuse Division's (ADAD) current assessment tools.
   2. Adding new attachments including the following:
      a. Fall Risk Assessment Tool to meet the Managed Long-Term Services and Supports (MLTSS) fall measure criteria,

b. Social Determinants of Health (SDOH) to meet SDOH requirements.

3. Extracting the "Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)" and "Patient Health Questionnaire-9 (PHQ-9)" items from the HFA and adding them as separate attachments.

D. HAP
   1. Adding EHCN in the population type section.
   2. Adding a new section "My Caregiver (Interdisciplinary Team)" to list all caregivers and other providers involved in the member's care and identify those who attend IDT meetings.
   3. Adding a new section labeled "Special Instructions" to serve as a reminder to the Health Coordinator (HC) to ensure that the documents listed have been completed and are up to date, to complete a re-assessment when necessary, and to initiate interventions to prevent falls if a member is at risk for falls.
   4. Re-arranging different sections to match with the sections in the HFA.
   5. Adding more specific tasks to the corresponding Electronic Visit Verification (EVV) task codes on personal and nursing care activities.
   6. Adding support services and programs, e.g., Behavioral Health Services, CIS, and Palliative Care.
   7. Adding the prison/jail and Hawaii State Hospital as options under Institutional Services section for future use.
   8. Re-arranging the services and supports sections by state agencies and non-state agencies and further separating state agencies by department.
   9. Adding more spaces to list other "areas of concern identified in the HFA"
   10. Changing the frequencies for HAP update and Home Visits from "months" to "days" to align with requirements.

E. Personal Assistance (PA) Tool and Skilled Nursing (SN) Tool
   1. Adding specific details under each personal care activities and nursing interventions to reflect the corresponding EVV task codes.

F. Instructions
   1. The instructions for completing the HFA and HAP forms and attachments and PA and SN tools were revised accordingly.

G. Printable Format

1. Med-QUEST Division (MQD) understands that the revised HFA and HAP will be integrated into existing health plan systems. As such, MQD will not require that the format of the HFA, HAP and other enclosures mirror the format of these documents as shared in this memo. However, each plan should be able to produce a readable and printable copy of the enclosed documents when requested by any authorized party. The format for reporting purposes will be addressed separately.

Please submit any questions to HCSBInquiries@dhs.hawaii.gov.

Enclosures: HFA & HAP Forms
HFA & HAP Instructions
Attachment Forms & Instructions
PA & SN Tools & Instructions

Table of Contents

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

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

Health Plan

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 <u>ATTACHMENT for QI Individualized Emergency Back-up Plan</u>. 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

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

☐ 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) i) Cannot read/limited 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

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

Health Plan

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

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

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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		

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

Health Plan

					☐ 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

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

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

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

Health Plan

	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:				

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

Health Plan

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:

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

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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

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

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

Health Plan

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

☐ (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:**

Health Plan

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	☐	☐	☐

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

Health Plan

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. _____

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

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.

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

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

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

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?

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

Health Plan

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?

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

Health Plan

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

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

Health Plan

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				

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

☐	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**

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

☐ **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:**

Health Plan

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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Member's Name:	**Medicaid #:**	**HAP Date: ____/____/____**

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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Member's Name:	**Medicaid #:**	**HAP Date: ____/____/____**	
		☐ 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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Member's Name:	Medicaid #:	HAP Date: ____/____/____

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

STATE OF HAWAII
QUEST Integration Health Action Plan (HAP)
Initial HAP Date: ____/____/____

Member's Name:	**Medicaid #:**	**HAP Date: ____/____/____**

☐	☐	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.

STATE OF HAWAII
QUEST Integration Health Action Plan (HAP)
Initial HAP Date: ____/____/____

Member's Name:	**Medicaid #:**	**HAP Date: ____/____/____**

☐ 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**

GENERAL INSTRUCTIONS

The Table of Contents may be formatted to go directly to the specific Sections.

Sections that do not apply to the member may be collapsed or hidden from view to provide a member-specific HFA.

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

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

All sections for the At Risk and LTSS program types must be completed by a licensed clinical staff.

Health Coordinators (HC) and Community Health Workers (CHWs) are expected to:

1. **Prepare for all visits using additional available resources (e.g., claims data, medication history, utilization history) and telephonic responses to expedite the assessment process and make the most of the member's time.**
2. **Confirm and validate all pre-filled information with the member.**

The assessment should include a face-to-face interview. Assessments and reassessments may be conducted by telehealth, based on member's choice and preference. If using telehealth, it must meet privacy requirements.

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

In accordance with the Home and Community-Based Setting Final Rule issued in January 2014, the following must be included in the planning process:

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

CHAPTER 1. NON-CLINICAL INFORMATION (Identification, Financial, Social Supports and Caregivers, and Home Information)

Section A
Section B
Section C
Section D
Section E
Section J (Attachments from Sections A-C)

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

A1. Member

a) Enter member's legal name (Last, First, Middle Initial).
b) Enter member's date of birth (MM/DD/YYYY).
c) Enter member's 10-digit Medicaid ID number.
d) Select whether member is a child or an adult (19 and over).
e) Select which program type member is currently in.

A2. Assessment

a) Check appropriate box to indicate the reason for assessment. See Appendix G Glossary for definitions.

If change in condition/status is checked, specify what type of change in condition/status occurred.

b) Fill-in Assessment Reference Information.

c) Fill-in Primary Assessor's legal name and title e.g., RN, SW, LSW, CHW etc.

d) Fill in Consult Assessor's legal name and title e.g., RN, SW, LSW etc.

e) Fill-in Additional Health Plan/Insurance, other than Medicare or Medicaid.

For questions i-iii, enter the Health Plan Name, Subscriber Name, and Subscriber Number, if applicable.

For question iv-v, answer question of whether they are a veteran and if they are receiving any veteran benefits.

f) Fill-in Medicare information:

For question i, select whether the member has Medicare coverage. If yes, indicate the Medicare ID number.

For question ii, select whether member has Medicare Advantage (delivered through a private health insurance company). If yes, indicate the plan name and ID.

g) Select whether the member has a legal guardian or authorized representative assisting in the assessment.

Indicate whether there were other individuals present. Enter all individuals that the member has chosen to assist in this assessment, with their legal name, their relationship to the member, their purpose in assisting member, and whether they were "Present", "Absent", or "Sent an Invite" (from drop down).

h) Provide comments, if appropriate.

A3. Legal Information

Check box if there is no change from previous assessment.

a) Check all appropriate boxes that identify individuals that have legal responsibilities regarding the member. For each box checked, identify whether a copy of the document legally delegating such responsibility was obtained for the Health Plan's record.

b) Answer questions for number i to ix for Advance Directives and Provider Orders for Life-Sustaining Treatment (POLST). For code status, include CPR order (Code or No Code), Medical Interventions (Comfort, Limited, Full, and additional orders if any), and Artificially Administered Nutrition status. Ensure that the POLST is signed and dated by the member or legally authorized representative and the provider in order for it to be valid.

c) Provide primary and secondary emergency contact information including their name, relationship to member, address, phone number, and email address.

d) If member is receiving HCBS, provide Emergency Plan by answering questions i - v. If answer to question iv is "No" (member did not complete their Individualized Emergency Back-up Plan), complete the Attachment for QI Individualized Emergency Back-Up Plan. Original should be attached to the HAP and a copy should go to the member. See Appendix G. Glossary for Definitions

e) Provide comments and identify any risk factors, if appropriate.

SECTION B. DEMOGRAPHIC INFORMATION
COMPLETE FOR ALL MEMBERS - - SHCN, EHCN, AT RISK, LTSS

B1. Demographics

Check box if there is no change from previous assessment.

a) Answer what sex was originally listed on member's birth certificate. If "Other" is selected, then describe.

b) Answer what gender(s) member identifies self as.

c) Answer what is member's preferred pronoun(s).

d) Click on drop down for member's current relationship status.

e) Select member's race/ethnicity. Check all that apply.

B2. Communication

Check box if there is no change from previous assessment.

a) Check member's primary means of communication. See Appendix G. Glossary for definitions

b) Check member's primary spoken language. Click on drop-down list to select.

c) Answer yes or no if member needs interpretation services. If yes, provide name and contact of interpreter.

d) Check primary written language for written materials. Click on drop-down list to select.

Answer how often member needs help to read instructions, pamphlets, or other material from the doctor or pharmacy. If member selects "sometimes" or "always", provide an explanation.

e) Answer yes or no if member needs translation services. If yes, provide name and contact of translator.

f) Provide other assistive communication device(s) (e.g., TTY, TTD, etc). Check none if member does not use any other assistive communication device(s).
g) Provide comments, if appropriate.

B3. Residence and Living Arrangements

Check box if there is no change from previous assessment.
a) Answer what is the member's living arrangement. Click on drop-down list to select. See Appendix G. Glossary for definitions.
b) Ask member where they have lived in the past 30 days. Select all that apply. See Appendix G. Glossary for definitions.
(1) If houseless, at risk of houselessness, NF/Acute care hospital transition, other is checked in section above, complete **Section B4. Housing Transitions for Going Home Plus (GHP).**
(2) Answer question if member is receiving housing navigation services. If no, answer question 3.
(3) Answer question "Have you ever been screened for CIS". Complete table from the drop-down list. Include the date and comment, if appropriate.
(4) If "Not Identified, Screened, or Referred" is selected in question #3 above, refer to CIS and add housing tasks to HAP.
c) Check type of Subsidized Housing . Select all that apply.
d) Provide comments, if appropriate.

B4. Housing Transitions for Going Home Plus

a) For Going Home Plus (GHP)
i) Answer yes or no if member has been in the nursing facility and/or acute care hospital for more than 60 continuous days.
ii) Answer yes or no if member meet nursing facility level of care. This is based on the DHS Form 1147 – member needs to have been designated as meeting ICF or NF level of care by MQD or designee.
iii) If the answers to i and ii are both yes, refer member to GHP. Select "Yes" if member meets both criteria and would like to be referred to GHP, select "Not Eligible" if one or both criteria are not met, or select "Declined/Family Refused" if member meets both criteria, but does not want to be referred to GHP.

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

C1. Finances

Check box if there is no change from previous assessment.
a) Answer the finances questions numbers i to ix.
i) Answer yes or no if member has concerns about their financial situation. If yes, select all that apply.
ii) Indicate what income sources member has. Select all that apply.
iii) Indicate member's employment status. Select all that apply.
iv) Answer yes or no if member or family members that live with them have been unable to get any of the following items (numbered 1-7). Select all that apply. If yes, complete Attachment for SDOH/SRF and attach to this HFA and/or make appropriate referral (see question ix).
v) Answer yes or no if member is worried about losing their housing. If yes, complete Attachment for SDOH/SRF and attach to this HFA and/or make appropriate referral (see question ix).
vi) Answer yes or no if member thinks it would be helpful to review their monthly expenses. If yes, complete Attachment for Financial Worksheet, attach to this HFA, and/or make appropriate referral (see question ix).
vii) Answer yes or no if member previously applied for additional services.
viii) Answer yes or no if member is in process of applying for additional assistance.
ix) Indicate what referrals member will be referred to. Select all that apply.
b) Provide comments and identify any risk factors, if appropriate.

C2. Social Supports

Check box if there is no change from previous assessment.
a) Provide information for Social Supports.
i) Check yes or no if there are family and/or friends living in the same residence. If yes, identify the name, age, relationship to member, contact number, and type of support provided (if applicable) to the member. Place an asterisk (*) next to the name if they are primary caregiver.
ii) Check yes or no if there are family and/or friends NOT living in the same residence but are providing support to the member. If yes, identify the name, age, relationship to member, contact number, and type of support provided to the member.

iii) Select yes or no if member has strong and supportive relationships with family.
iv) Select yes or no if member has strong and supportive relationships with a friend or neighbor.
v) Ask member if they prefer having family or friends accompany them or help them when they go to medical appointments. Select yes, no, or no opinion.

b) Provide comments and identify any risk factors, if appropriate.

C3. Caregivers

Check box if there is no change from previous assessment.
Identify any caregivers. Include their name, age, relationship to member, phone number, type of help provided, whether they are through outside employment (i.e. agency), the employer's name if applicable, and the number of hours they work for the member per week.

a) Provide the Primary Caregiver's name.
i) This section will be an interview with the Primary Caregiver on their perspective. Assess member's primary caregiver status for possible caregiver burn out using suggested bullet points to start the conversation. HC or CHW and providers must be able to identify whether the primary caregiver is experiencing caregiver burnout to coordinate caregiver supports, e.g., respite care, education, and and/or counseling, etc.

b) Provide comments and identify any risk factors, if appropriate.

SECTION D. TRANSPORTATION
COMPLETE FOR ALL MEMBERS - - SHCN, EHCN, AT RISK, LTSS
Do not complete for NF/CCFFH/E-ARCH

a) Answer questions regarding transportation.
i) Identify whether the lack of transportation has kept member from medical appointments, meetings, work, or from getting things needed for family living. Check all that apply.
ii) Identify current mode of transportation. Select all that apply.
CCFFH and E-ARCH caregivers are responsible for transporting residents.
If member selects "Drives own vehicle" or "Family or Friends", you may skip to Section E.
If member selects neither, complete remaining questions of this section (iii-x).

b) Provide comments and identify any risk factors, if appropriate.

SECTION E. HCBS HOME ENVIRONMENT
COMPLETE FOR MEMBERS - - AT RISK, LTSS
** Complete only for HCBS and do not complete if member is in NF/CCFFH/E-ARCH***

a) Answer questions for current home
a1) Answer questions for safety. Select ALL that apply.
a2) Answer questions for accessibility. Select ALL that apply.
For question iii – Identify if THERE ARE accessibility issues to the specified areas (#1 – #7). If yes, select ALL that apply.
a3) Answer questions for electronic connectivity/communication.
a4) If there are any concerns noted above regarding safety, accessibility, and/or electronic communication, describe interventions to address those concerns in the Health Action Plan (HAP).

b) Answer questions regarding exterior of home. Provide comments as needed, to present a thorough assessment.

c) Answer question regarding interior of home. In the "Other" space, provide information if there are pets in the home and if the home is smoker-free. Provide comments as needed, to present a thorough assessment.

d) Provide comments and identify any risk factors, if appropriate.

Chapter 2. CLINICAL INFORMATION (Health Status, Medical Care Conditions, Needs, and Services, Functional Abilities, Psychosocial Well-Being, and Long-Term Services and Supports Information)

SHCN/EHCN

Section F
Section G
Section H
Section I
Section J (Attachments from Sections F-H)
Section K

SECTION F. MEDICAL INFORMATION
COMPLETE FOR ALL MEMBERS - - SHCN, EHCN, AT RISK, LTSS

F1. Disease Diagnosis(es)

Check box if there is no change from previous assessment.

a) In the first column, list all member's disease diagnosis(es). In the second column, list the corresponding ICD-10 code for each the diagnosis. In the third column, include the date the diagnosis was made. If unsure, select box for unknown. Refer to Appendix E for list of disease diagnoses that require the completion of disease specific attachments, if applicable to member, and attach to this HFA.

b) Provide comments and identify any risk factors, if appropriate.

F2. Transplant

Check box if there is no change from previous assessment.

a) Answer questions i-iii regarding transplant, if applicable.

b) Provide comments and identify any risk factors, if appropriate.

F3. Medications (Prescribed and OTC)

Check box if there is no change from previous assessment.

Answer questions i-viii regarding medications. Attach current Medication list with start date, dose, frequency, and instructions to the HAP and/or complete Attachment for Medications, if appropriate, and attach to the HAP.

F4. Treatment and Therapy(ies)

Check box if there is no change from previous assessment.

Provide information for each column. Refer to Appendix A for list. If therapy is not listed in Appendix A, select "Other", and note the treatment or therapy in the table.

Note: Complete Skilled Nursing Tool for any treatment or therapy, if applicable. Refer to Appendix A for treatment and therapies that require assessment with Skilled Nursing Tool (identified with an asterisk).

F5. Medical Equipment and Supplies

Check box if there is no change from previous assessment.

Provide information for each column. Refer to Appendix B for list. If therapy is not listed in Appendix B, select "Other" and note the equipment or supply on the table.

Note: Complete Skilled Nursing Tool for any treatment or therapy, if applicable. Refer to Appendix B for medical equipment and supplies that require assessment with Skilled Nursing Tool (identified with an asterisk).

F6. Physician(s) and Provider(s)

Check box if there is no change from previous assessment.

Provide information for each column. List the primary physician/provider(s) first.

F7. Utilization of Hospital, Emergency Room, and Physician Services

Check box if there is no change from previous assessment.

a) Answer whether member needed medical attention within the past three (3) months. If yes, ask if they were able to get help by phone and/or by telehealth. Select yes or no for each follow-up item.

b) Answer question of how many times member was hospitalized within the past three (3) months for physical health, mental health, and/or SUD. For each category, select one checkbox for the number of times. In the proceeding column for each category, indicate the cumulative number of days the member was hospitalized.

c) Answer question of how many times member was in the emergency room within the past three (3) months for physical health, mental health, and/or SUD. Select only one for each column.

d) Answer question on how many times member stayed at a crisis home or unit in the past three (3) months. In the first column, select one box for the number of times the member stayed in a crisis home or unit within the past three months. In the second column, indicate the cumulative number of days the member stayed in a crisis home or unit within the past three months.

e) Answer questions regarding physician services last visit and next schedule visit. If unknown, indicate the reason.

f) Provide comments and identify any risk factors, if appropriate.

F8. Prevention & Immunizations

Check box if there is no change from previous assessment.

a) Answer screening questions. Answer questions i and ii for children only. Answer questions iii to v for all members.

b) Answer questions i-vi for members in HCBS residential or institutional settings.

c) Provide comments and identify any risk factors, if appropriate.

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

G1. Cognition

Check box if there is no change from previous assessment.

a) Answer questions regarding cognition.
   i) Answer yes or no if member is comatose? If yes, skip to Section G4.
   ii) Mental Status. Choose one (1) answer from (a), (b), or (c):
      (a) Check box to indicate if member is oriented to person, place, time, and situation.
      Use guide below to help determine mental status – orientation:
      Here are suggestions to help determine orientation:
         (1) What is your name? (Person)
         (2) Do you know where you are? (Place)
         (3) What is today's date or year? (Time)
         (4) What is happening right now (or) What are we doing? (Situation)
      If member is unable to answer any of the questions correctly, they don't meet the criteria for oriented and should be considered disoriented (options b or c below).

      (b) Check box to indicate if member is partially or intermittently disoriented and/or requires supervision. Provide an explanation.
      (c) Check box to indicate if member is disoriented and/or disruptive. Provide and explanation.

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

b) Answer questions i-iv regarding wandering.
c) Provide comments and identify any risk factors, if appropriate.

G2. Vision/Hearing/Speech & Communication

Check box if there is no change from previous assessment.

a) Answer questions for vision.
   Answer yes or no if member is visually impaired or struggles with vision loss.
   Answer questions about vision impairment and corrective lenses. Select all that apply from i-iii.
   Indicate the date of the member's last eye exam. If unknown or member declines to answer, check appropriate box.
b) Answer questions for hearing.
   Answer yes or no if member is hard of hearing or hearing impaired.
   Answer questions about hearing impairment and assistive device(s) for hearing. Select all that apply from i-iii.
   Describe if member uses a hearing aid for one or both ears or if member uses another type of device (e.g. amplifier).
   Indicate the date of the member's last hearing exam. If unknown or member declines to answer, check appropriate box.
c) Answer questions for speech.
   i) Select best option for member's speech pattern from options 1-3.
   ii) Indicate the date of the member's last speech evaluation. If unsure or if member has not had a speech evaluation, select box for unknown.
d) Answer questions for communication.
   i) Select best option for member's ability to verbally express ideas from options 1-3.
e) Answer questions for comprehension.
   i) Select best option for member's ability to understand others from options 1-4.
f) Provide comments and identify any risk factors, if appropriate.

G3. Mood, Behavior, and Psychological Well-Being – PHQ9 for Adults / PSC 17 for Children

Check box if there is no change from previous assessment. Check if member is enrolled in CCS.

a) Answer questions i-ii for PHQ-2. If there is a score of three (3) or greater on the PHQ-2, complete Attachment PHQ-9 for Adults or complete the Pediatric Symptom Checklist for Children in part b. Otherwise, skip to question c.
   Note that questions b-e are for children only
b) Complete Depression (Pediatric Symptom Checklist) only if they scored 3 or greater on the PHQ-2 in part a. If they score 15 or higher on the Pediatric Symptom Checklist, refer member to their PCP or refer for a behavioral health evaluation.

c) Ask parent/guardian question c for the child member. If they select yes, refer member to their PCP or refer for a behavioral health evaluation.
d) Ask parent/guardian question d for the child member. If they select yes, refer member to their PCP or refer for a behavioral health evaluation.
e) Check box if making a referral and specify. This should be done if score on the Pediatric Symptom Checklist is 15 or higher.

Note that questions f-m are for adults only

f) Answer yes or no if adult member has had any recent major life stressor(s). If yes, provide an explanation.
g) Answer question for coping skills. Select all that apply from options i-iii.
h) Answer question for anger. Select all that apply from options i-ii. If option ii is checked, provide an explanation.
i) Answer question for anxiety. Select all that apply from options i-iii.
j) Answer question for behavior. Indicate if this information is gathered from observing the behavior or member/guardian answering. Select all that apply from options i-vi. If option vi is checked, provide an explanation.
k) Answer question for social relationships. Select all that apply from options i-iii. If any of the options is/are checked, provide an explanation.
l) Answer yes, no, or does not apply to question regarding whether member has an order from physician for use of physical restraints.
If yes, answer parts ii and iii by selecting the type of restraint(s) used. Indicate the appropriate code for limitation coding for each type of restraint.
m) Provide comments and identify any risk factors, if appropriate. Identify provider referrals, if any.

G4. Health Status

Check box if there is no change from previous assessment.

a) Take and enter vital signs (required for LTSS). Mode refers to the method by which the vital sign was taken. For example, pulse can be taken with a pulse oximeter, feeling for a radial pulse, or taking an apical pulse with a stethoscope.
b) Answer questions for fall history.
   i) Answer yes or no if member has problems with balance or gait or is a risk of falls.
   ii) Answer yes or no if member has a history of falls.
   iii) Select all that apply from options 1-3.
   iv) Indicate the number of falls member has had within the past year. This can be a witnessed fall, a self-reported fall, or if member was found on the ground.
   v) Indicate the number of fall-related injuries member has had within the past year.
   vi) Indicate the date of the member's last fall.

   If member is 18 years or older and has had at least one fall with injury or at least two falls with/without injury within the past year, complete the Attachment for Fall Risk Assessment and attach to this HFA.
c) Answer questions for pain. If member is verbal and able to answer, use the Numeric Rating Scale. If member is non-verbal or is verbal but unable to answer appropriately, use the Faces Pain Rating Scale.
d) Answer questions for substance and/or drug use. If response is "yes" for smoking use, complete Tobacco Screener. If response is yes for alcohol use or substance/drug use, complete CAGE-AID Screener.
e) Provide comments and identify any risk factors, if appropriate. If any referral was made, specify.
f) Answer questions for cardiac/respiratory**. If any of the boxes i-x are checked, complete Attachment for Heart Disease and attach to this HFA. If box x is checked, complete Attachment for Asthma/COPD/Respiratory/Tracheostomy/Ventilator and attach to this HFA.**
g) Provide comments and identify any risk factors for section f, if appropriate.

G5. Nutrition

Check box if there is no change from previous assessment.

a) Answer questions for height, weight, and Body Mass Index (BMI). To calculate BMI, you may use an online BMI calculator or calculate using this formula: Calculate the member's weight (pounds) x 703. Take this answer and divide by the member's height (inches). Take this answer and divide again by the member's height (inches). Ensure that you are using a recent height and weight to calculate an accurate BMI.
b) Answer questions for dental:
   i) whether member has any natural teeth that are broken, fragmented, loose, or non-intact.
   ii) whether member has dentures. If yes, indicate if they are full or partial dentures.
   iii) whether member uses their dentures. If no, indicate the reason they do not.

iv) whether member is experiencing any toothache or pain (either chewing or at rest). If yes, make appropriate dental referral.
v) note the date of member's last dental exam.

c) Answer questions for weight loss or gain.
i) When answering this question, include typical foods/drinks that member consumes. Also include the time-of-day member eats these items.
ii) A special diet can be the types of food/drink recommended – for example, cardiac diet, no concentrated sweets (NCS), no added salt (NAS), etc.
iii) Answer yes or no if the member show any signs and symptoms of possible chewing and/or swallowing disorder or difficulty. Check all the options that apply.
iv) Answer question for planned/unplanned weight loss.
v) Answer question for planned/unplanned weight gain.
vi) Answer question of whether physician or provider counseled member on weight loss or weight gain.
vii) Answer yes or no of whether there is a plan for managing member's weight. If yes, describe the plan.

d) Answer questions for Nutritional Intake**. If member requires tube or parenteral feedings, refer to Skilled Nursing Tool to determine allotted hours.**
i) Answer yes or no if member is able to eat by mouth.
ii) Answer yes or no if member is able to feed themselves independently, without the assistance from others or with or without assistive devices (i.e. weighted utensils, plate guard, etc.)
iii) Indicate if member has any dietary modifications.
a) Food may be regular, chopped, minced, or pureed. Select appropriate box(es). Note that while most dietary modification orders apply to all foods, there may be exceptions with approval from provider or consent from member or guardian.
b) Liquids may be thickened to either nectar, honey, or pudding consistency. Select appropriate box(es). Note that while most thickened liquid orders apply to all liquids member consumes, there may be exceptions with approval from provider or consent from member or guardian.
iv) Answer yes or no if member requires enteral feedings. If yes, indicate if it is via NG tube, GT, or G/J tube.
v) Answer yes or no if member requires parenteral feedings. If yes, indicate if it is via TPN or other (describe).

e) Provide comments and identify any risk factors, if appropriate.

G6. Continence

Check box if there is no change from previous assessment.

a) Answer questions for bladder and bowel continence. If option #2 is selected, describe the type of catheter or ostomy and size (if applicable).
b) Answer yes or no if member uses incontinence products. If yes, describe (e.g., incontinent briefs, underwear liner, etc.).
c) Provide comments and identify any risk factors, if appropriate. If member uses a catheter or has an ostomy, provide information about the care provided. This includes how often the device is changed, instructions if the tube becomes dislodged, how often the bag is emptied, and the care instructions/frequency.

G7. Skin

Check box if there is no change from previous assessment.

a) Answer questions for skin. Select all that apply. For those selected, provide a description. HC and provider(s) must be able to identify any skin problems to coordinate and provide appropriate services as needed.
b) Provide comments and identify any risk factors, if appropriate.

G8. Musculoskeletal

Check box if there is no change from previous assessment.

a) Answer questions for Bones, Muscles, or Joints. Select all that apply. For those selected, provide description. HC, CHWs, and provider(s) must be able to identify any bone, muscle, or joint problems that affect functional activities to coordinate and provide appropriate services as needed.
b) Provide comments and identify any risk factors, if appropriate.

G9. Family Planning

Check first box if there is no change from previous assessment or not applicable.
Answer questions for reproductive health.

i) Ask member if they are sexually active. If member is an adolescent or younger, approach this question delicately and use best judgement. The purpose of asking this question is to lead up to the following questions in this section. For example, question iv below asks about birth control.
ii) Answer yes, no, or N/A for whether member is pregnant. **If yes, complete the ATTACHMENT for Pregnancy and attach to this HFA.**
iii) Answer if member would like to become pregnant in the next year. Select one option.
iv) Answer yes or no if member is currently using birth control. If yes, indicate the type being used. Answer yes or no if they are satisfied with their birth control. If they are not satisfied, provide reason.

Answer questions 1-3.

b) Provide comments and identify any risk factors, if appropriate.

G10. Functional Status **COMPLETE FOR AT-RISK, LTSS**

Check box if there is no change from previous assessment.

a) Answer questions for Long-Term Services and Supports (LTSS) to assess function and document the level of assistance needed to complete ADLs and IADLs.

i) Answer yes or no if member has concerns about taking care of themselves. Include member's response in the ATTACHMENT for iADLs and ADLs.
ii) Answer yes or no if member has a caregiver (family member/friend or agency) that assists them with their daily activities.
iii) Answer yes or no if member identifies any assistance and/or services that they need to remain in their home.
iv) Complete the ATTACHMENT for iADLs and ADLs and attach to this HFA and to the HAP.

G11. Self-Reported Health

Check box if there is no change from previous assessment.

a) Ask member how they would describe their health in general. Select one box. If they select "Fair" or "Poor", ask member questions b-d. If not, skip to section H.
b) Ask member how many days their physical health was not good in the past 30 days.
c) Ask member how many days their mental health was not good in the past 30 days.
d) Ask member how many days their poor physical or mental health keep them from doing their usual activities, such as self-care, work, or recreations.

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

H1. Member's Perspective

Check box if there is no change from previous assessment.

Answer questions a-h for personal history/lifestyle/goals. The strategy should be to "talk story" with the member and use the provided questions as a guide. Ask appropriate questions that are currently relevant to the member. If member shows no interest in answering interview questions, skip this section and document in comments section. If unable to obtain information from member, you may obtain from parents, others, etc.

i) Complete Attachment for One Page Description and attach to the HAP.

SECTION I. CURRENT SERVICES AND SUPPORTS
COMPLETE IF APPROPRIATE FOR MEMBERS IN SHCN, EHCN, AT RISK, LTSS

I1. Home and Community Based Services (HCBS) **COMPLETE FOR AT RISK, LTSS**

Check box if there is no change from previous assessment or not applicable.

Complete only for LTSS/At Risk.

a) List the HCBS Services, provider(s)/agency(ies) that provide those services, the frequency/amount of those services, and any comments or additional needs. Refer to Appendix C for list.

Document frequency/amount of services provided per week, e.g., 10 hours per week, 2 sessions per week, 10 times per week.

b) Provide comments, if appropriate.

I2. Institutional Services **COMPLETE LTSS**

Check box if there is no change from previous assessment or not applicable.

a) List the institutional services, the provider of those services, and any comments or additional needs. Provide the start date of the service, if applicable. Refer to Appendix D for list.

b) Provide comments, if appropriate.

I3. Additional Support Services **COMPLETE FOR SHCN, EHCN, AT RISK, LTSS**

Check box if there is no change from previous assessment or not applicable.

a) Answer questions i-ii for State Program(s).
   i. Answer yes or no if member is currently receiving any services from any State Programs.
   ii. Indicate which school the member is attending. If not applicable to member, select N/A.
   Select the State Program(s) that member is participating in and enter the referral date and/or enrollment start date. Provide the contact name for the State Program, phone number and email address, agency name (if applicable), and any other additional information. If member is enrolled in a State Program that is not listed here, provide this information on the row for "Other".
   If unknown, check box for unknown.

b) Provide comments, if appropriate.

c) Provide information for Non-State Program(s). Provide Non-State Program, contact name, phone number, services/hours. If unknown, check box for unknown.

d) Provide information for referrals. Select the applicable type of referrals, note the contact name, phone number, and services/hours.

e) Provide comments, if appropriate.

SECTION J. ATTACHMENTS SECTION
COMPLETE IF APPROPRIATE FOR MEMBERS IN SHCN, EHCN, AT RISK, LTSS

The following attachment document questionnaire are triggered by certain items or questions in the HFA. Check ALL that apply, complete the attachment, and attach 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
☐ G4.f ATTACHMENT FOR Asthma, Chronic Obstructive Pulmonary Disease (COPD), Respiratory/Tracheostomy/Ventilator
☐ G9.a ATTACHMENT FOR Pregnant Female
☐ G10.a ATTACHMENT FOR IADLs and ADLs
☐ H1.j ATTACHMENT FOR One Page Description – MY PROFILE

Complete disease specific questions for those that have been identified in Section F1a. Disease Diagnosis(es). HC and CHW will ask relevant questions appropriate to the member to gather information for HAP.

Check ALL that apply, complete the attachment, and 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/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 ALL MEMBERS - - SHCN, EHCN, AT RISK, LTSS

a) Describe and provide summary of visit and include answers for questions i-iv.

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

L1. Provide the Name, Signature, and Title of individuals completing the HFA. In the Sections column, note what sections that individual completed. In the Date Section Completed column, indicate the date the sections were completed. If an individual completed more sections on different days, list these separately.
L2. Provide the Name, Signature, and Date of when the Health Coordination Licensed Clinical Staff reviewed and approved the completion of the HFA. Please note that this may be the same person indicated in section L1.

APPENDICES

Appendix A. Treatments and Therapies

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

Appendix B. Medical Equipment and Supplies

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

Appendix C. HCBS Services

1. Adult Day Care (ADC)
2. Adult Day Health (ADH)
3. Assisted Living Facility (ALF)
4. Community Care Management Agency (CCMA) Services
11. Moving Assistance
12. Non-Medical Transportation
13. Personal Assistance Services – Level I (PA I)
14. Personal Assistance Services – Level II (PA II)

5. Counseling and Training
6. Community Care Foster Family Home (CCFFH)
7. Environmental Accessibility Adaptations (EAA)
8. Expanded-Adult Residential Care Home (E-ARCH)
9. Home Delivered Meals
10. Home Maintenance
15. Personal Assistance Services – Level II (Delegated) (PA II- Delegated)
16. Personal Emergency Response Systems (PERS)
17. Respite Care
18. Skilled (or private duty) Nursing (SN)
19. Specialized Medical Equipment and Supplies
99. Other

Appendix D. Institutional Services

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

Appendix E. Diseases

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

Appendix F. Additional Acronyms

1. **ABA** Applied Behavioral Analysis
2. **ADAD** Alcohol and Drug Abuse Division
3. **ADC** Adult Day Care
4. **ADH** Adult Day Health
5. **ADLs** Activities of Daily Living
6. **AIDS** Acquired Immunodeficiency Syndrome
7. **ALF** Assisted Living Facility
8. **AMHD** Adult Mental Health Division
9. **APS** Adult Protective Services
10. **AR** Authorized Representative
11. **ARCH** Adult Residential Care Home
12. **ASL** American Sign Language
13. **BH** Behavioral Health
14. **BMI** Body Mass Index
15. **BPM** Beats Per Minute
16. **CAGE-AID** Cut, Annoyed, Guilty, Eye-opener - Adapted to Include Drugs
17. **CAMHD** Child and Adolescent Mental Health Division
18. **CBCM** Community Based Case Management
19. **CCFFH** Community Care Foster Family Home
20. **CCMA** Community Care Management Agency
21. **CCS** Community Care Services
22. **CDPA** Consumer-Directed Personal Assistance
23. **CIS** Community Integration Services
24. **CHW** Community Healthcare Worker
25. **CM** Case Manager
26. **CMO** Comfort Measures Only
27. **CNA** Certified Nurse Assistant
28. **COVID** Coronavirus Disease
29. **CPR** Cardiopulmonary Resuscitation
30. **CSAC** Certified Substance Abuse Counselor
31. **CWS** Child Welfare Services
52. **GT** Gastrostomy tube
53. **IADLs** Instrumental Activities of Daily Living
54. **ICF** Intermediate Care Facility
55. **ID** Intellectual Disabilities
56. **ID #** Identification number
57. **IDT** Interdisciplinary Team
58. **IEP** Individual Educational Plan
59. **ISP** Individual Service Plan
60. **ITP** Individual Treatment Plan
61. **LIHEAP** Low Income Home Energy Assistance Program
62. **LOC** Level of Care
63. **LPN** Licensed Practical Nurse
64. **LSW** Licensed Social Worker
65. **LTSS** Long-Term Services and Supports
66. **L/min** Liter per minute (Oxygen concentrator setting)
67. **MCSA** Member Care Service Associate
68. **MH** Mental Health
69. **MQD** Med-QUEST Division
70. **NA** Not Available, Not Applicable, Not Appropriate
71. **NF** Nursing Facility
72. **NG** Nasogastric (tube)
73. **OB-GYN** Obstetrics-Gynecologist
74. **OT** Occupational Therapy
75. **PA** Personal Assistance
76. **PCP** Primary Care Provider
77. **PERS** Personal Emergency Response Systems
78. **PHN** Public Health Nurses
79. **PHQ** Patient Health Questionnaire
80. **POA** Power of Attorney
81. **POLST** Provider Orders for Life-Sustaining Treatment

32. **DD** Developmental Disabilities
33. **DDD** Developmental Disabilities Division
34. **DHS** Department of Human Services
35. **DOE** Department of Education
36. **DOH** Department of Health
37. **EAA** Environmental Accessibility Adaptations
38. **E-ARCH** Expanded Adult Residential Care Home
39. **EHCN** Expanded Health Care Needs
40. **EPSDT** Early and Periodic Screening, Diagnostic, Treatment
41. **ER** Emergency Room
42. **FIO2** Fraction of Inspired Oxygen
43. **HFA** Health and Functional Assessment
44. **HAP** Health Action Plan
45. **HC** Health Coordinator(s)
46. **HCBS** Home and Community-Based Services
47. **HH** Home Health
48. **HIV** Human Immunodeficiency Syndrome
49. **HP** Health Plan
50. **GHP** Going Home Plus
51. **G/J** Gastrojejunostomy (tube)
82. **PPD** Purified Protein Derivative
83. **PS** Pressure support (ventilator setting)
84. **PSD** Department of Public Safety
85. **PT** Physical Therapy
86. **QI** QUEST Integration
87. **RN** Registered Nurse
88. **SDOH** Social Determinants of Health
89. **SHCN** Special Health Care Needs
90. **SHOTT** State of Hawaii Organ and Tissue Transplant
91. **SMES** Specialized Medical Equipment/Supplies
92. **SN** Skilled Nursing (Private Duty)
93. **SNAP** Supplemental Nutrition Assistance Program
94. **SNF** Skilled Nursing Facility
95. **SRF** Social Risk Factors
96. **SSI** Supplemental Security Income
97. **ST** Speech Therapy
98. **SW** Social Worker
99. **SUD** Substance Abuse Disorder
100. **TB** Tuberculin
101. **TPN** Total Parenteral Nutrition
102. **VOC Rehab** Vocational Rehabilitation Division
103. **Vt** Tidal Volume (ventilator setting)

Appendix G. Glossary

For A2.a: Reason for Assessment

1. **Initial** – An assessment that is conducted for the first time.
2. **6-month assessment –** An assessment that is conducted every six (6) months for a member in CCFFH, E-ARCH, and ALF
3. **Annual –** An assessment that is conducted every 12 months.
4. **Member Request** – An assessment that is conducted at member's request.
5. **Change of Condition/Status –** An assessment conducted other than what is listed above. Enter other type of assessment e.g., a reassessment that is conducted within ten (10) days when significant events occur in the life of a member, including but not limited to, the death of a caregiver, significant change in health status, change in living arrangement, institutionalization and change in provider(s) (if the provider(s) change affects the service plan) follow up reassessment, request by Member or authorized representative when Member is experiencing any changes in situation or condition

For A3.d: Emergency Plan

Emergency Back-up plan – this is to ensure member has emergency caregivers, transportation, and DME/life support.
Emergency Plan – this is to ensure there is a plan for natural disasters.

For B2.a: Primary Means of Communication

i) **Verbal –** Member is able to communicate verbally.
ii) **Non-Verbal –** Member is unable to communicate verbally but is able to communicate by using hand gestures, facial expressions, eye contact, body language, etc.
iii) **Written –** Member is unable to communicate verbally but prefers to and able to communicate in writing.
iv) **American Sign Language –** Member is able to communicate through Sign Language primarily used in the United States.
v) **Other –** Enter type of communication, e.g., speech communicating device, etc.

For B3.a: Living Arrangement

i) **Alone –** Lives by self.
ii) **With spouse/partner only –** Lives with spouse or partner, boyfriend or girlfriend.
iii) **With spouse/partner and other(s) –** Lives with spouse or partner and other individual(s), whether family or unrelated.
iv) **With child (not spouse/partner) –** Lives with child(ren) only, or child(ren) and other individual(s) but not spouse or partner.

v) **With parent(s)/guardian(s) –** Lives with parent(s) or guardian(s) only, or with parent(s) or guardian(s) and other individual(s) but not spouse or partner or child(ren).
vi) **With sibling(s) –** Lives with sibling(s) only, or sibling(s) and other individual(s) but not spouse or partner, parent(s) or guardian(s) or child(ren).
vii) **With other relative(s) –** Lives with relative(s) (i.e., aunt or uncle) only, or relative(s) and other individual(s) but not spouse or partner, parent(s) or guardian(s), sibling(s) or child(ren).
viii) **With non-relative(s) –** Lives in a group setting (e.g., NF, CCFFH, etc).
ix) **Other**

For B3.b: Residence

i) **Own private house/apartment –** Any house, apartment, or condominium owned by the member.
ii) **Rent private house/apartment/room –** Any house, apartment, condominium, or room rented by the member.
iii) **Houseless (with or without shelter) –** Member has no permanent residence (a house, apartment, condominium, room, or a place to stay on a regular basis). Member may reside on the streets, in a car, in open areas, or at a homeless shelter, e.g., Institute for Human Services (IHS), etc.
iv) **At risk of houselessness** – Member who will lose their primary nighttime residence.
v) **Assisted Living Facility (ALF) –** A licensed facility that consists of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility shall be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.
vi) **Adult Residential Care Home (ARCH) –** A licensed facility that provides twenty-four (24) hour living accommodations, for a fee, for five unrelated people who require minimal assistance in the activities of daily living and do not need assistance from skilled, professional personnel on a regular long-term basis.
vii) **Expanded-Adult Residential Care Home (E-ARCH) –** A licensed facility that provides twenty-four (24) hour living accommodations, for a fee, for five unrelated people who require at least minimal assistance in the activities of daily living and who may need the professional health services provided in an intermediate care facility or skilled nursing facility. There are two types of E-ARCHs:
Type I – allowing five (5) or fewer residents and up to six (6) residents may be allowed at the discretion of the department with no more than (3) nursing facility level residents; and
Type II – allowing six (6) or more residents with no more than twenty (20%) nursing facility level residents of the home's licensed capacity.
viii) **Foster Home (Children) –** A home that a minor has been placed into as a ward of the State.
ix) **DD Adult Foster Home/DD Dom – DD Adult Foster Home –** A private home in which care, training, and supervision are provided on a twenty-four (24) hour basis for not more than two (2) adults with developmental or intellectual disabilities (DD/ID) who are unrelated to the foster family at any point in time. **DD Domiciliary Homes** – Individuals in a DD Dom setting need supervision or care, but do not need the professional health services of a registered nurse. A DD Dom serves adults with intellectual or developmental disabilities (DD/ID) unrelated to the caregiver. A DD Dom is allowed to serve up to five (5) DD/ID individuals.
x) **Community Care Foster Family Home (CCFFH) –** A certified home that provides twenty-four (24) hour living accommodations, including personal care and homemaker services.
xi) **Nursing Facility (NF) –** A licensed facility that provides appropriate care to persons referred by a physician. Such persons are those who: need twenty-four (24) hour a day assistance with the normal activities of daily living; need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis; and, may have a primary need for twenty-four (24) hours of skilled nursing care on an extended basis and regular rehabilitation services.
xii) **NF transition –** Member is currently residing in a NF and with ongoing discharge planning.
xiii) **Rehabilitation hospital/unit –** Any licensed acute care facility, e.g., Rehabilitation Hospital of the Pacific, in the service area to which a member is admitted to rehabilitation services pursuant to arrangements made by a physician.
xiv) **Psychiatric hospital/unit –** Any licensed acute care facility, e.g., Kahi Mohala Behavioral Health, Kekela at Queens Medical Center, in the service area to which a member is admitted to receive psychiatric services pursuant to arrangements made by a physician.
xv) **Acute care hospital –** Any licensed acute care facility in the service area to which a member is admitted to receive. inpatient services pursuant to arrangements made by a physician.
xvi) **Acute care hospital transition –** Member is currently in an acute care hospital and with ongoing discharge planning.

xvii) **Other –** If "Other," enter current residence e.g., ICF-ID

xviii) **Other/Transition** – Member is currently in a setting not listed above **(**e.g., prison or state hospital)

For G3: Mood, Behavior, and Psychological Well-Being

a) PHQ-2 – Code items i and ii 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.

STATE OF HAWAII
Health Action Plan Instructions

General Instructions:
In accordance with the HCBS Setting Final Rule issued in January 2014, the health action plan must be person-centered 42 CFR 441.301 (C) (1)-(2). eCFR: 42 CFR 441.301 -- Contents of request for a waiver.

For the header:

1. Provide the Initial Health Action Plan (HAP) Date. The Initial HAP Date at the top of the page represents the date of the first HAP for the member.
2. Provide the Member Name, Member Medicaid ID#, and HAP Date.
   For the initial assessment, the HAP Date is the same as the initial HAP date. For each reassessment, the HAP Date is the same as the date of the reassessment.

Indicate the member's age cohort by checking the appropriate box.
Indicate the member's program type by checking the appropriate box.

SECTION A. AUTHORIZATION OF MY SUPPORT SERVICES

A1. Member/Authorized Representative (AR).

This section is member or AR's attestation indicating that they directed the HAP meeting to the maximum extent possible; the member and/or AR was enabled to make informed choices and decisions in the meeting; and, the member and/or AR reviewed and agreed to the support services written in the plan.

1. Provide the member's name, signature, and date.
2. Provider the AR's name, signature, and date.
3. Indicate who directed the meeting. If someone other than the member directed the meeting, explain why.

A2. Health Coordinator(s) (HC)

1. Provide the lead health coordinator's name, signature, title, and date.
2. Provide the consulting health coordinator's name, signature, title, and date.

A3. Copy of HAP given to

1. Provide the names of the PCP and support provider(s).
2. Give/Send a copy of the HAP to the Primary Care Provider's (PCP) and the support provider(s).

MY CAREGIVERS (INTERDISCIPLINARY TEAM (IDT))

1. Provide the designated point of contact for all IDT members.
2. List all natural supports, caregivers, and other providers who are involved in the member's care. Indicate whether these individuals are invited and/or attend any of the IDT meetings by checking the box under yes, no, or not applicable (n/a).
   Provide business or agency name in the spaces provided, if applicable.

SPECIAL INSTRUCTIONS

1. Check the appropriate box(es) to indicate whether the listed information is available and up to date.

Information	Additional instructions	Location in the HFA
Advance Directives	Attach copy to the HAP	A3.b.iv
POLST	Specify the location of POLST copy in the home. Check boxes to indicate code status and treatment based on the POLST.	A3.b vi-viii A3.d Attachment QI Individualized Emergency Back-Up Plan
Emergency Contact List		A3.c A3.d Attachment QI Individualized Emergency Back-Up Plan
Infection Control Guidelines	Refer to "Resources/Handouts for Infection Control in the Home" section of this instructions	
List of Allergies		F3.viii
Recent (within 90 days) Hospitalization	Recent means since the last HAP update or within the last 90 days	F7.b
Recent (within 90 days) ER visit	Recent means since the last HAP update or within the last 90 days	F7.c
Fall Risk		G4.b (including Attachment for Fall Risk Assessment)

2. Provide "Other" information, if appropriate.

SECTION B to J. MY GOALS AND MY ACTIONS

Complete this section using member's own words as much as possible. Document the findings identified in the HFA sections B-J using the template provided in this section.

Important TO me (My Goals)	Enter the member's (person-centered) desired outcome. Check the box to indicate that the goal has been met.
Start Date	Enter the start date of the goal.
Modified Date:	Enter the date that a revision was made to the member's HAP for each need identified, if applicable. If no revision was made or member declined, enter "N/A".
Next Review Date	Enter the next review date of the goal with the member.
My strengths and great things about me Enter the member's strengths related to the member's identified goal. Enter things that other people like and admire or other great things about the member.	
My Preferences/Choices	Enter member's preferences and choices related to the member's identified goal.
Barriers	Identify and enter any barriers to the member completing the action(s).
Past Efforts to Meet Goal	Enter prior efforts the member has made to meet this goal previously. Both successful and unsuccessful efforts should be documented, as well as the approximate time frame these efforts were made.
Important FOR me (My Actions)	Enter the actions or interventions that move the member towards the identified goal. These are the steps that will be taken to assist the member in reaching the desired outcome.
Who Will Help Me	Identify and enter who will assist the member in performing the action, in applicable. The member may specify that they will complete this action alone.
Action Progress	Track progress of the specific action. The HC will mark whether the action has 'Not Started', is 'In Progress', has been 'Completed', or 'Member declined'. This will help the member track their progress towards meeting their goal.
Progress Note	The HC and member can use this section to update notes specific to the action. It can be used to demonstrate why an action has not yet been started, or why an action has remained in progress.

Example:

Important TO me (My Goal) # 1: *I will remain in my home.* **Start Date:** *12 / 12 / 2023* **Modified Date:** _____/ _____/ _____ **Next Review Date:** *01 / 12 / 2024* ☐ **Please check this box when member has attained this goal.**			
My strengths and great things about me *I can feed myself after my meal has been set up in front of me.* *People tell me that they love my determination no matter the hardships I have faced.*	**My Preferences/Choices** *I prefer to remain in my home with assistance from my family and/or other paid caregivers.*	**Barriers** *I need assistance in my ADLs due to left-sided weakness from stroke 2 years ago.*	**Past Efforts to Meet Goal** **(Include successful & unsuccessful efforts** *Successful - My family assisted when any of the paid caregivers were not available in the past 2 years.*
What is important FOR me (My Actions)	**Who Will Help Me**	**Action Progress**	**Progress Note**
I will have assistance in shopping for food and preparing meals for the next 3 months.	*Home Health Agency or my mother*	☐ **Not Started** ☒ **In Progress** ☐ **Completed** ☐ **Member declined**	*I continue to need assistance in shopping for my food and preparing my meals.*
I will continue to feed myself after my meal has been set up in front of me for the next 3 months	*No help*	☐ **Not Started** ☒ **In Progress** ☐ **Completed** ☐ **Member declined**	*I continue to be independent.*
		☒ **Not Started** ☐ **In Progress** ☐ **Completed** ☐ **Member declined**	

SECTION F. DISEASE MANAGEMENT/EDUCATION

This section is for members that need referrals for disease management/education.
In the first column, identify and enter learning needs related to the different diagnoses listed in Section F1. Disease Diagnosis (es) in the HFA. For each learning need, enter the provider's name and contact information, frequency/amount and duration of service, and any relevant information in the subsequent columns.
Document frequency/amount of services provided per week, e.g., 10 hours per week, 2 sessions per week, 10 times per week.

SECTION F-G. MY SUPPORT PLAN DETAILS

Complete this section to indicate the tasks that need to be completed by the health plan, paid caregiver, or self-directed PA services based on member's needs, risks, and issues as identified in sections F-G in the HFA.

1. Check all applicable tasks to the member.
2. Document frequency/amount of services provided per week, e.g., 10 hours per week, 2 sessions per week, 10 times per week.
   Enter specific instructions which may include member's personal preferences, member's abilities, instructions for agencies, and doctor's orders, if applicable. Examples include:
   - Special lotion
   - Time of bath
   - Member has right-sided weakness.
   - Member to comb own hair or brush own teeth.
   - Document observation of wound size, odor, drainage, etc. when performing wound care.
   - Toileting hygiene: The ability to maintain perineal/feminine hygiene, adjust clothes before and after toileting. If managing an ostomy, include wiping the opening but not managing equipment.
3. Note that tasks with an asterisk (*) are to be completed by skilled nursing RN/LPN only.

SECTION I. MY SUPPORT PLAN

Complete this section using information from section I in the HFA.

1. Check all services and supports applicable to the member.
2. Identify and enter the start date, the provider(s) (including natural supports), the frequency/amount, and duration of each of the services and supports.
   Document frequency/amount of services provided per week, e.g., 10 hours per week, 2 sessions per week, 10 times per week.
3. Complete I3.d. Referrals for members that require referrals for service(s)/specialty(ies). Identify and enter the type of referral, the provider's name and contact information, the frequency/amount and duration of the service and support, and any additional relevant comments.
   Document frequency/amount of services provided per week, e.g., 10 hours per week, 2 sessions per week, 10 times per week.

Items that do not apply to the member:

1. *should be marked N/A*
2. *may be collapsed or hidden from view to provide a member-specific HAP print out.*

SECTION K. SUPPORT PROVIDER RESPONSIBILITIES

1. All LTSS HAP must identify the Consulting Health Coordinator. The HC will check all team member responsibilities that apply to the member. Check "Other" for responsibilities that are not listed and describe.
2. Fill in the text boxes, if appropriate.

SECTION L. ADDITIONAL COMMENTS

1. This section is for text entry for any additional relevant comments that should be communicated to the member or the caregiver that is not otherwise captured in the HAP. Examples include safety concerns, pet information, gaps in care. If not applicable to the member, it is not required to be filled out.
   This section may also be used to enter any risk modification plan(s) based on the results of the following surveys (Refer to the Health Plan Manual - Appendices):
   a. Appendix AC: HCBS Provider Attestation and Evidence Tool
   b. Appendix AE: Health Plan HCBS Member Satisfaction Survey
2. Identify and enter other areas of concern identified in the HFA and prioritize.

Resources/Handouts for Infection Control in the Home

Hand Hygiene

New_HandWash_Poster (who.int)

When and How to Wash Your Hands | Handwashing | CDC

Standard Precautions

Standard Precautions (cdc.gov)

WHO-UHL-IHS-IPC-2022.1-eng.pdf

APPENDICES	
Appendix A. Treatments and Therapies	
1. BiPAP/CPAP 2. Catheter care 3. Chemotherapy 4. Chest physiotherapy 5. Cough Insufflator/Exsufflator* 6. Dialysis 7. Enteral Feeding* 8. Home Health 9. Hospice care 10. IV therapy* 11. Occupational therapy 12. Oxygen therapy	13. Palliative care 14. Personal Emergency Response System (PERS) 15. Physical therapy 16. Psychological therapy 17. Radiation 18. Respiratory therapy 19. Speech language therapy 20. Suctioning* 21. Tracheostomy care* 22. Transfusion 23. Ventilator care* 24. Wound care* 99. Other
Appendix B. Medical Equipment and Supplies	
1. Bath chair/shower bench 2. BiPAP/CPAP 3. Cane 4. Catheter Supplies 5. Chest Vest 6. Commode 7. Cough Insufflator/Exsufflator* 8. Enteral Feeding Supplies* 9. Feeding Pump* 10. Grab bars 11. Handheld shower head 12. Hospital Bed 13. Incontinence supplies 14. Nebulizer* 15. Ostomy Supplies	16. Oxygen concentrator* 17. Oxygen tank* 18. Patient lift 19. Personal Emergency Response System (PERS) 20. Pulse oximeter* 21. Scooter 22. Specialty mattress 23. Stander 24. Suction machine* 25. Toilet Chair 26. Tracheostomy Supplies* 27. Transfer board 28. Walker 29. Wheelchair 99. Other
Appendix C. HCBS Services	
1. Adult Day Care (ADC) 2. Adult Day Health (ADH)	10. Home Maintenance 11. Moving Assistance

3. Assisted Living Facility (ALF) 4. Community Care Management Agency (CCMA) Services 5. Counseling and Training 6. Community Care Foster Family Home (CCFFH) 7. Environmental Accessibility Adaptations (EAA) 8. Expanded Adult Residential Care Home (E-ARCH) 9. Home Delivered Meals	12. Non-Medical Transportation 13. Personal Assistance Services – Level I (PA I) 14. Personal Assistance Services – Level II (PA II) 15. Personal Assistance Services – Level II (Delegated) (PA II-Delegated) 16. Personal Emergency Response Systems (PERS) 17. Respite Care 18. Skilled (or private duty) Nursing (SN) 19. Specialized Medical Equipment and Supplies 99. Other
Appendix D. Institutional Services	
1. Acute Waitlisted ICF/SNF 2. Nursing Facility (NF), Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF)	3. Sub-Acute Facility 4. Rehabilitation Center
Appendix E. Diseases	
1. Asthma 2. Cancer 3. Chronic Obstructive Pulmonary Disorder (COPD) 4. Diabetes 5. End Stage Renal Disease (ESRD) 6. Heart Disease 7. Hepatitis B/C	8. High Blood Pressure 9. HIV/AIDS 10. Respiratory/Tracheostomy/Ventilator use 11. Seizures 12. Transplant 99. Other
Appendix F. Acronyms	
1. **ADAD** Alcohol and Drug Abuse Division 2. **ADC** Adult Day Care 3. **ADH** Adult Day Health 4. **ADLs** Activities of Daily Living 5. **AIDS** Acquired Immunodeficiency Syndrome 6. **ALF** Assisted Living Facility 7. **AMHD** Adult Mental Health Division 8. **APS** Adult Protective Services 9. **AR** Authorized Representative 10. **ARCH** Adult Residential Care Home 11. **ASL** American Sign Language 12. **BH** Behavioral Health 13. **BMI** Body Mass Index 14. **CAMHD** Child and Adolescent Mental Health	41. **HCBS** Home and Community-Based Services 42. **HH** Home Health 43. **HIV** Human Immunodeficiency Syndrome 44. **G-tube** Gastrostomy tube 45. **IADLs** Instrumental Activities of Daily Living 46. **ICF** Intermediate Care Facility 47. **ID** Intellectual Disabilities 48. **ID #** Identification Number 49. **IDT** Interdisciplinary Team 50. **LIHEAP** Low Income Home Energy Assistance Program 51. **LOC** Level of Care 52. **LPN** Licensed Practical Nurse 53. **LSW** Licensed Social Worker 54. **LTSS** Long-Term Services and Supports

	Division
15. **CBCM**	Community Based Case Management
16. **CCFFH**	Community Care Foster Family Home
17. **CCMA**	Community Care Management Agency
18. **CCS**	Community Care Services
19. **CDPA**	Consumer-Directed Personal Assistance
20. **CIS**	Community Integration Services
21. **CHW**	Community Healthcare Worker
22. **CM**	Case Manager
23. **CMO**	Comfort Measures Only
24. **CNA**	Certified Nurse Assistant
25. **CPR**	Cardiopulmonary Resuscitation
26. **CSAC**	Certified Substance Abuse Counselor
27. **CWS**	Child Welfare Services
28. **DD**	Developmental Disabilities
29. **DDD**	Developmental Disabilities Division
30. **DHS**	Department of Human Services
31. **DOE**	Department of Education
32. **DOH**	Department of Health
33. **EAA**	Environmental Accessibility Adaptations
34. **E-ARCH**	Expanded Adult Residential Care Home
35. **EHCN**	Expanded Health Care Needs
36. **EPSDT**	Early and Periodic Screening, Diagnostic, Treatment
37. **ER**	Emergency Room
38. **FIO2**	Fraction of Inspired Oxygen
39. **HAP**	Health Action Plan
40. **HC**	Health Coordinator(s)
55. **L/min**	Liter per minute (Oxygen concentrator setting)
56. **MCSA**	Member Care Service Associate
57. **MH**	Mental Health
58. **MQD**	Med-QUEST Division
59. **NF**	Nursing Facility
60. **OB-GYN**	Obstetrics-Gynecologist
61. **OT**	Occupational Therapy
62. **PA**	Personal Assistance
63. **PCP**	Primary Care Provider
64. **PERS**	Personal Emergency Response Systems
65. **PHN**	Public Health Nurses
66. **POA**	Power of Attorney
67. **POLST**	Provider Orders for Life-Sustaining Treatment
68. **PS**	Pressure support (ventilator setting)
69. **PSD**	Department of Public Safety
70. **PT**	Physical Therapy
71. **RN**	Registered Nurse
72. **SHCN**	Special Health Care Needs
73. **SMES**	Specialized Medical Equipment/Supplies
74. **SN**	Skilled Nursing (Private Duty)
75. **SNAP**	Supplemental Nutrition Assistance Program
76. **SNF**	Skilled Nursing Facility
77. **ST**	Speech Therapy
78. **SW**	Social Worker
79. **SUD**	Substance Abuse Disorder
80. **VOC Rehab**	Vocational Rehabilitation Division
81. **Vt**	Tidal Volume (ventilator setting)

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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)

Personal Assistance Tool

Member Name:						*Medicaid #:*								*Date of Assessment:*							
Task		**Total Minutes of Care Required/Week**				**Total Minutes of Care Performed by Unpaid Support System/Week**								**Total Minutes of Care Performed by Health Plan Provider/Week**							
		Frequency/ Day	Minutes/ Task	Days/ Week	Total Minutes/ Week	SUN	MON	TUE	WED	THU	FRI	SAT	Total Minutes/ Week	SUN	MON	TUE	WED	THU	FRI	SAT	Total Minutes/ Week
Personal Assistance Level 1																					
1	Routine House Cleaning ☐**Bathroom (0200)** ☐**Kitchen (0205)** ☐ **Bedroom (0210)** ☐**Changing linen (0215)** ☐**Make bed (0220)** ☐**Empty Trash (0225)**																				
2	Laundry ☐**Washing (0230)** ☐**Drying (0235)** ☐**Ironing (0240)** ☐**Mending (0245)**																				
3	Shopping/Errands **(0250)**																				
4	Transportation/Escort **(0255)**																				
5	Meal Preparation **(0260)**																				
6	Companion **(0265)**																				
7	Other																				
Personal Assistance Level 2																					
1	Eating/Feeding ☐**Prepare/Serve (0300)** ☐ **Assist/Feed (0305)** ☐**Record Oral Intake (0310)**																				
2	Bathing ☐**Bed Bath (0315)** ☐**Shower (0320)** ☐**Shampoo (0325)**																				
3	Dressing (Upper and Lower Body) ☐**Upper Body (0330)** ☐ **Lower Body (0335)**																				

4	Grooming/Personal Hygiene ☐**Oral care (0340)** ☐**Shave (0345)**																				
5	Hair and Skin care ☐**Brush (0350)** ☐**Comb (0355)** ☐**Nail Care (0360)** ☐**Foot Care (0365)** ☐**Skin care (0367)**																				
6	Toileting (**do not include transfer and ambulation) (0370)**																				
7	Ambulation																				
8	Bed Mobility/Transfers **(0375)**																				
9	Manual Wheelchair Mobility (**0377)**																				
10	Medication Assistance ☐**Remind (0385)** ☐**Assist (0380)**																				
12	*Other: _(see attached task Description) _____																				
SUBTOTAL MINUTES/WEEK				**Total Minutes/Week**									**Total Minutes/Week**							**Total Minutes/Week**	

Total Minutes of Care Required/Week	
Total Minutes of Care Performed by Unpaid Support System/Week	
Total Minutes of Care Performed by Health Plan Provider/Week	
Total Hours of Care Performed by Health Plan Provider/Week	
Total Hours of Care Performed by Health Plan Provider/Month (based on 7Days/Week x 31Days/Month)	

Justification for Allocation of Hours:

Assessor Signature **Print Name/Title**

Instructions for Personal Assistance Tool

The State recommends that this tool be formatted in Excel for calculation functionality.

1. **Member Name** - Enter member's legal name (Last, First, Middle Initial). If a member has no middle initial, leave blank.
2. **Medicaid #** - Enter member's Medicaid Identification Number.
3. **Date of Assessment** - Enter date assessment was completed.
4. **Daily Activities -** Select the activity and the corresponding EVV task code.
5. **Degree of Assistance** - The assessor will determine the member's degree of assistance using the completed Attachment for IADLs and ADLs included in the HFA.
    a. *Independent* - No assistance, set up, or supervision.
    b. *Minima l*- Able to complete some tasks with assistance, includes oversight, encouragement or cueing, or supervision.
    c. *Moderate* - Able to complete some of task but need assistance with most of task to complete the task.
    d. *Total* - Unable to complete the task on own or needs total assistance to complete the task.
6. **Suggested Times (Minutes) -** The assessor will enter the minutes based on the Degree of Assistance. Refer to Table 1. Personal Assistance Guidelines for allocating hours. If the minutes exceed the maximum suggested minutes, please document reason in the Justification for Allocation of Hours.

Table 1. Personal Assistance Guidelines

Personal Assistance Level 1

<table>
<tr><th colspan="2">Tasks</th><th colspan="2" rowspan="2">Degree of Assistance and Suggested Times</th></tr>
<tr><td>Personal Assistance Level 1</td><td>Description</td></tr>
<tr><td rowspan="8">Routine House Cleaning

☐Bathroom (0200)
☐Kitchen (0205)
☐Bedroom (0210)
☐Change linen (0215)
☐Make bed (0220)
☐Empty Trash (0225)</td><td rowspan="8">• Dusting
• Cleaning up after personal care tasks (bathing, toileting, meal preparation, etc.)
• Cleaning floors in living areas used by member
• Cleaning counters, stovetop, washing dishes
• Carrying out trash and setting out garbage for pickup
• Emptying and cleaning bedside commode
• Cleaning bathroom (floor, toilet,</td><td rowspan="2">Minimum</td><td>Member that lives alone: Up to 120 minutes per week</td></tr>
<tr><td>Member that lives with family or friends: Up to 60 minutes per week</td></tr>
<tr><td rowspan="2">Moderate</td><td>Member that lives alone: Up to 180 minutes per week</td></tr>
<tr><td>Member that lives with family or friends: Up to 120 minutes per week</td></tr>
<tr><td rowspan="2">Total</td><td>Member that lives with alone: Up to 120 minutes per week</td></tr>
<tr><td>Member that lives with family or</td></tr>
</table>

	tub/shower, sink) • Changing bed linens • Making up bed		*friends:* Up to 180 minutes per week
Laundry ☐Washing (0230) ☐Drying (0235) ☐Ironing (0240) ☐Mending (0245)	• Gathering and sorting • Hand washing garments • Loading and unloading of washer or dryer in residence • Hanging clothes to dry • Folding and putting away clothes • Laundromat	• *Member has a washer and dryer:* Up to 60 minutes per week. • *Member has no washer and dryer but has a laundromat on premises:* Up to 90 minutes per week. • *Member has no washer and dryer, and laundromat is not within walking distance:* Up to 120 minutes per week	
Shopping/Errands ☐ Shopping/ Errands (0250)	• Preparing shopping list • Grocery shopping • Picking up medication, medical supplies, or household items • Putting groceries away • Paying bills	• *Member that lives alone:* Up to 90 minutes per week • *Member that lives with family or friends:* Up to 60 minutes per week	
Transportation/Escort ☐Transportation/Escort (0255)	• Transportation arrangements • Accompanying member to doctor's office, clinic or other trips made for the purpose of obtaining medical diagnosis or treatment. • Wait time at the doctor's office or clinic with a member when necessary due to member's condition and/or distance from home.	• As needed. • *Member that lives alone:* Up to 90 minutes per week visit • *Member that lives with family or friends:* Up to 90 minutes per week visit	

Meal Preparation ☐ Meal Preparation (0260)	• Meal planning • Preparing foods • Cooking full meal • Warming up prepared food • Cutting food for member • Serving food • Grinding and pureeing food	**Minimum**	Up to 10 minutes per meal
		Moderate	Up to 20 minutes per meal
		Total	Up to 30 minutes per meal
Companion ☐Companion (0265)	• Accompanying member on daily task that helps to accomplish daily living skills/task.	• As needed. • *Member that lives alone:* Up to 90 minutes per week visit • *Member that lives with family or friends:* Up to 90 minutes per week visit	
Other **-** List Other Personal Assistance Level 1 not listed above, e.g., light yard work, simple home repairs		• As needed. • Up to 60 minutes per week.	

Personal Assistance Level 2

Tasks		**Degree of Assistance and Suggested Times**	
Personal Assistance Level 2	Description		
Eating/Feeding ☐Prepare/Serve (0300) ☐ Assist/Feed (0305) ☐Record Oral Intake (0310)	• Standby assistance and encouragement • Assistance with using eating or drinking utensils or adaptive devices. • Spoon feeding • Bottle feeding	**Minimum**	Up to 5 minutes per meal
		Moderate	Up to 20 minutes per meal
		Total	Up to 30 minutes per meal
Bathing ☐Bed Bath (0315) ☐Shower (0320) ☐Shampoo (0325)	• Standby assistance • Drawing water in sink, tub or basin • Hauling/heating water • Gathering and setting up supplies • Assisting with transferred in/out of tub or shower • Sponge bath • Bed bath	**Minimum**	Up to 5 minutes per bath
		Moderate	Up to 30 minutes per bath
		Total	Up to 45 minutes per bath

	• Washing, rinsing, and toweling the body or body parts		
Dressing (Upper Body) ☐Upper Body (0330)	• Undressing • Dressing • Gathering and laying out clothes • Assisting with applying on and removing orthotics or prosthetic devices	**Minimum**	Up to 5 minutes per activity
		Moderate	Up to 20 minutes per activity
		Total	Up to 30 minutes per activity
Dressing (Lower Body) ☐ Lower Body (0335)	• Undressing • Dressing • Gathering and laying out clothes • Assisting with applying on and removing orthotics or prosthetic devices	**Minimum**	Up to 5 minutes per activity
		Moderate	Up to 20 minutes per activity
		Total	Up to 30 minutes per activity
Grooming/Personal Hygiene ☐Oral care (0340) ☐Shave (0345)	• Gathering and laying supplies • Oral care- brushing teeth, cleaning dentures • Shaving facial or body hair	**Minimum**	Up to 5 minutes per task
		Moderate	*Female:* Up to 30 minutes per task
			Male: Up to 15 minutes per task
		Total	*Female:* Up to 45 minutes per task
			Male: Up to 30 minutes per task
Hair and Skin care ☐Brush (0350) ☐Comb (0355) ☐Nail Care (0360) ☐Foot Care (0365) ☐Skin care (0367)	• Laying out supplies • Washing hair • Drying hair • Combing/brushing hair • Washing hands and face • Applying nonprescription lotion to skin	**Minimum**	Up to 5 minutes per task
		Moderate	*Female:* Up to 30 minutes per task
			Male: Up to 15 minutes per task
		Total	*Female:* Up to 45 minutes per task

			Male: Up to 30 minutes per task
Toileting (do not include transfer and ambulation) ☐ Toileting (0370)	• Standby assistance • Assisting with clothing during toileting • Preparing toileting equipment and supplies • Assisting with feminine hygiene needs • Assisting with toilet hygiene such as use of toilet paper and hand washing • Assisting on/off bed pan • Assisting with urinal • Brief changes • Colostomy bag empty/change • External catheter change • Catheter bag empty/change	**Minimum**	Up to 10 minutes per activity
		Moderate	Up to 20 minutes per activity
		Total	Up to 30 minutes per activity
Ambulation	• Assisting member in positioning for use of assistive devices • Standby assistance • Assisting with ambulation using steps • Assisting with ambulation indoor/outdoor	**Minimum**	Up to 5 minutes per activity
		Moderate	Up to 15 minutes per activity
		Total	Up to 30 minutes per activity
Bed Mobility/Transfers ☐ Bed Mobility/Transfers (0375)	• Assisting/repositioning in Bed/Chair • Assisting Chair/Bed transfer • Assisting Toilet transfer • Assisting Car transfer • Hoyer lift transfer	**Minimum**	Up to 5 minutes per activity
		Moderate	Up to 15 minutes per activity
		Total	Up to 30 minutes per activity
Manual Wheelchair Mobility ☐ Manual Wheelchair Mobility (0377)	• Assisting Indoors/Outdoors	Up to 30 minutes per day	
Medication Assistance ☐Remind (0385) ☐Assist (0380)	• Medication reminding • Getting a glass of water • Bringing medication container to member	Up to 15 minutes per day	

	• Opening medication container at request of member	
Other – Other PA2 not listed above	• Checking and reporting any equipment or supplies that need to be repaired or replenished. • Taking and recording vital signs, including blood pressure	Up to 30 minutes per day.

7. **Total Minutes of Care Required/Week**
    a. *Frequency/Day* - Enter how many times the member needs the task done each *day*.
    b. *Minutes/Task* - Enter how many minutes it takes to do the task each time.
    c. *Days/Week* - Enter how many days a task is needed in a week. Most tasks are done daily, but there may be tasks that may be done once or twice a week etc.
    d. *Total Minutes/Week* - Minutes will be added up and totaled at the end of column. This provides the assessor with the ability to check that all minutes required per week are performed by either Support System or Health Plan Provider.
    e. *For example: A member needs assistance with meal preparation 3 times a day. It takes 10 minutes each time which will total 30 minutes required per day and total 210 minutes per week.*
8. **Total Minutes of Care Performed by Unpaid Support System/Week**
    a. *Frequency Per Day/Total Minutes Per Week* - The assessor will ask how many times a task is done for the member by Support System which includes care provided by family, friends, or other programs such as DDD, DOE, etc. Enter how many minutes the member needs the task done each *day* and place it on the appropriate day of the week for each task.
    b. *Total Minutes/Week* - Minutes will be added up and totaled at the end of column. This provides the assessor with the total minutes per week that will be performed by the Support System.
    c. For example: Support System will provide assistance with meal preparation 2 times daily, 20 minutes per day, which total 140 minutes per week.
9. **Total Minutes of Care Performed by Health Plan Provider/Week**
    a. *Frequency Per Day/Total Minutes Per Week* - The assessor must calculate the Health Plan Provider frequency of tasks each day and the total time based on all the information entered into the form.
    b. *Total Minutes/Week* - Minutes will be added up and totaled at the end of column. This provides the assessor with the total minutes per week that will be performed by the Health Plan Provider.
    c. *For example: The Paid Caregiver will provide meal preparation 1 time daily, 10 minutes per day, which total 70 minutes per week.*
10. **Subtotal Minutes/Week**
    a. Total Minutes of Care Required/Week - Total time the tasks take to perform per week.
    b. Total Minutes of Care Performed by Support System/Week - Total time the Support System performs the task per week.

c. Total Minutes of Care Performed by Health Plan Provider/Week - Total time the Health Plan Provider performs the task per week.

11. **Final Calculation of Hours**
    a. The assessor will recheck totals and then calculate total minutes to hours.
    b. All fields will need to be populated:
       Total Minutes of Care Required/Week
       Total Minutes of Care Performed by Unpaid Support System/Week
       Total Minutes of Care Performed by Health Plan Provider/Week
       Total Hours of Care Performed by Health Plan Provider/Week
       Total Hours of Care Performed by Health Plan Provider/Month (based on 7 Days/Week x 31 Days/Month)
12. **Justification for Allocation of Hours -** Provide reason(s) the hours are more than the suggested times.
13. **Assessor Signature -** The licensed health coordinator must print name/title and sign the tool to acknowledge that the appropriate hours have been allotted.

Skilled Nursing Tool

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

	Nursing Intervention	Frequency/Complexity	Suggested Time (Minutes)	Total Minutes of Care Required/Week				Total Minutes of Care Performed by Support System/Week								Total Minutes of Care Performed by Health Plan Provider/Week							
				Frequency /Day	Minutes/ Task	Days/ Week	Total Minutes/ Week	SUN	MON	TUE	WED	THU	FRI	SAT	Total Minutes/ Week	SUN	MON	TUE	WED	THU	FRI	SAT	Total Minutes/ Week
1	Ventilator Care ☐ Ventilator Care (540) ☐ Check Ventilator Settings (0545) Type: FIO2 %, VT, Peep , Rate , PS	>12 hours (per day)	Up to 40																				
		<12 hours (per day)	Up to 30																				
2	BIPAP/CPAP Care	>12 hours (per day)	Up to 40																				
		<12 hours (per day)	Up to 30																				
3	Tracheostomy Care (0535)	Per day	Up to 15																				
4	Suctioning (oral, nasal, tracheal) ☐Oral Suctioning (0505) ☐ Suctioning non-oral* (0510)	Per episode	Up to 10																				
5	Nebulization therapy (0515)	Per episode	Up to 15																				
6	Cough insufflators and exsufflators	Per episode	Up to 15																				
7	Chest vest therapy	Per episode	Up to 15																				
8	Nutrition (parenteral, G-tube, J-tube) ☐ Record Feeding Intake (0450) ☐Tube Feeding* (0455) Feeding Orders: _____ ☐G-Tube care (0460) ☐Monitor skin condition for adequate hydration (0465)	Bolus feeds per episode	Up to 15																				
		Continuous (per day)	Up to 30																				
9	Special Skin Care (wounds, burns, ulcers, G/J tube site care) ☐ Decubitus Care (0600) ☐ Dressing (0605) ☐Clean (0610) ☐Sterile*(0615)	Simple (dry gauze, tape) per episode	Up to 10																				
		Moderate (duoderm) per episode	Up to 15																				
		Complex (per episode)	Up to 20																				
10	Orthopedic appliance ☐Transfer - Patient Lift (0925)	Splint/cast per episode	Up to 10																				
		Complex (describe) per episode	Up to 20																				
11	Urinary bladder catheterization, irrigation ☐Urinary Catheterization* (0825) ☐Catheter Care (0830) ☐ Catheter Irrigation* (0835) ☐ Condom care (0840) ☐ Empty Urine Drainage Bag (845)	Per episode	Up to 15																				

	☐ Record Output (850) ☐ Drain bag: Empty ½ full or more often (855)																						
12	Vascular access catheter care	Per day	Up to 15																				
13	Ileostomy/colostomy care	Per day	Up to 20																				
14	Medications administered by LPN/RN (oral, nasal, ophthalmic, ear, enteral-G or J tube, rectal, IM, subcu) ☐ See Medication Sheet and administer as ordered by physician* (0700) ☐Update medication list (0705) ☐ All caregivers to know medication, purpose, effects, and side effects	Per dose	Up to 10																				
15	Intravascular medications	Per dose	Up to 15																				
16	Monitors	Cardio-respiratory (per day)	Up to 10																				
		Pulse oximeter (per day)	Up to 10																				
17	Glucose Monitoring (0170)	Per episode	Up to 10																				
18	*Other: _(see attached task Description) _____																						
	SUBTOTAL SKILLED MINUTES/WEEK			**Total Minutes/Week**				**Total Minutes/Week**								**Total Minutes/Week**							

Total Minutes of Care Required/Week	
Total Minutes of Care Performed by Support System/Week	
Total Minutes of Care Performed by Health Plan Provider/Week	
Total Hours of Care Performed by Health Plan Provider/Week	
Total Hours of Care Performed by Health Plan Provider/Month (based on 7Days/Week x 31Days/Month)	

Justification for Allocation of Hours:

Assessor Signature **Print Name/Title**

Instructions for Skilled Nursing Tool

The State recommends that this tool be formatted in Excel for calculation functionality.

1. **Member Name**- Enter member's legal name (Last, First, Middle Initial). If a member has no middle initial, leave it blank.
2. **Medicaid #**: Enter member's Medicaid Identification Number.
3. **Date of Assessment**: Enter date assessment was completed.
4. **Nursing Intervention:** Select the Intervention and the corresponding EVV task.
5. **Frequency/Complexity-** How often and complexity of skill.
6. **Suggested Times (Minutes) -** The assessor will enter the minutes based on the frequency and complexity of each skill. If the minutes exceed the maximum suggested minutes, please document reason in the Justification for Allocation of Hours.
7. **Total Minutes of Care Required/Week**
    a. *Frequency/Day*- Enter how many times the member needs the skill done each *day*.
    b. *Minutes/Task*- Enter how many minutes it takes to do the skill each time.
    c. *Days/Week*- Enter how many days a skill is needed in a week. Most skills are done daily, but there may be something like an IM injection that may be done once or twice a week etc.
    d. *Total Minutes/Week*- Minutes will be added up and totaled at the end of column. This provides the assessor the ability to check that all minutes required per week are performed by either Support System or Health Plan Provider.
    e. *For example: A member gets nebulizer treatments 3 times a day and it takes 10 minutes each time which will total 30 minutes required per day. Treatment orders are daily which total 210 minutes per week.*
8. **Total Minutes of Care Performed by Unpaid Support System/Week**
    a. *Frequency Per Day/Total Minutes Per Week*- The assessor will ask how many times a skill is done for the member by Support System which include care provided by family, friends, or other programs such as DDD, DOE etc. Enter how many minutes the member needs the skill done each *day* and place in the appropriate day of the week for each skill.
    b. *Total Minutes/Week*- Minutes will be added up and totaled at the end of column. This provides the assessor the total minutes per week that will be performed by the Support System.
    c. For example: Support System provides 2 nebulizer treatments daily, 20 minutes per day, which total 140 minutes per week.
9. **Total Minutes of Care Performed by Health Plan Provider/Week**
    a. *Frequency Per Day/Total Minutes Per Week*- The assessor must calculate the Health Plan Provider frequency of skills each day and the total time based on all the information entered into the form.
    b. *Total Minutes/Week*- Minutes will be added up and totaled at the end of column. This provides the assessor the total minutes per week that will be performed by the Health Plan Provider.
    c. *For example: The Paid Caregiver will provide 1 nebulizer treatment daily, 10 minutes per day, which total 70 minutes per week.*
10. **Subtotal Skilled Minutes/Week**
    a. Total Minutes of Care required/Week- Total time the skills take to perform per week.
    b. Total Minutes of Care Performed by Support System/Week- Total time the Support System performs per week.

c. Total Minutes of Care Performed by Health Plan Provider/Week-Total time the Health Plan Provider will perform per week.

11. **Final Calculation of Hours**
    a. The assessor will recheck totals and then calculate total minutes to hours.
    b. All fields will need to be populated:
       Total Minutes of Care Required/Week
       Total Minutes of Care Performed by Unpaid Support System/Week
       Total Minutes of Care Performed by Health Plan Provider/Week
       Total Hours of Care Performed by Health Plan Provider/Week
       Total Hours of Care Performed by Health Plan Provider/Month (based on 7 Days/Week x 31 Days/Month)
12. **Justification for Allocation of Hours –** Provide reason the hours are more than the suggested times.
13. **Assessor Signature-** The assessor must print and sign tool to acknowledge that the appropriate hours have been allotted.