JOSH GREEN, M.D.
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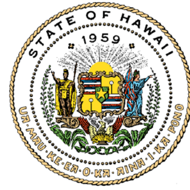

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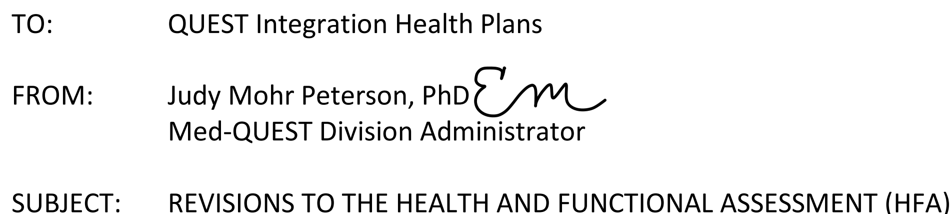
August 15, 2024

MEMORANDUM

MEMO NO.
QI-2416

TO: QUEST Integration Health Plans



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

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

This memorandum informs the health plans of the revisions to the content of the HFA form and instructions. The revisions were made to align with the National Committee for Quality Assurance (NCQA) standards and in response to feedback from health plans and other stakeholders. Health plans are required to use the new version of these documents effective January 1, 2025.

Significant revisions include:

1. Deleted the language that excludes members residing in nursing facilities (NF) and Community Care Foster Family Home (CCFFH) from needing to complete Section E. HCBS Home Environment. Removed “HCBS” and added “facility” to the section title and throughout the section, as appropriate. This is to align with NCQA MLTSS-1 Comprehensive Assessment and Update (CAU) measure specification ensuring a home safety risks assessment is completed. Plans are required to complete Section E on members residing in NFs and CCFFHs effective immediately.
2. Deleted references to an Attachment B3.b Housing Screener.
3. Instructions were revised accordingly.

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

Enclosures

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

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

Health Plan

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

A1. Member

a) Member Name ______ (Last) ______ (First) ______ (MI)
b) Date of Birth __/__/____
c) Medicaid ID# ______

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

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 ATTACHMENT for QI Individualized Emergency Back-up Plan. Attach original copy to the HAP and provide a copy to member.**

e) Comments – Identify any risk factors: ______

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

B1. Demographics ☐ No Change from Previous Assessment

a) What sex was originally listed on your birth certificate:	b) Do you identify as:	c) Preferred Pronoun(s):	d) Relationship Status
☐ 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		(Click on drop down to select) Choose an item. Describe other ______

e) Race/Ethnicity – Check all that apply

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

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

B2. Communication ☐ No Change from Previous Assessment

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

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) <u>i) Cannot read/limited</u> 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, **<u>complete Section B.4 Housing Transitions for Going Home Plus (GHP)</u>**

(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

☐ (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 **<u>Primary Caregiver about their current status.</u>** 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

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. HOME/FACILITY ENVIRONMENT — COMPLETE FOR AT RISK, LTSS

*****Do not complete if member is in E-ARCH*****

a) Current Home/Facility
Check **ALL** that apply:
a1) Safety
☐ i) Member feels safe in the home/facility.
☐ 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/facility 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/Facility 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/Facility 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:**

Health Plan

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

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:	/ /	☐ Unknown
Other Provider visit. Type: ______ NEXT scheduled visit:	/ /	☐ Unknown
Other Provider visit. Type: ______ NEXT scheduled visit:	/ /	☐ Unknown

f) Comments – Identify any risk factors: ______

F8. Prevention & Immunizations ☐ No Change from Previous Assessment

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+, <u>complete the ATTACHMENT for Cognition and attach to this HFA.</u>

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

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	☐	☐	☐

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: ______

☐ (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.**

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

<table>
<tr>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td colspan="2">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.</td>
</tr>
</table>

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

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?

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				

☐	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**
☐ **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**

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

☐ **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

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)

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 for 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. HOME/FACILITY ENVIRONMENT
COMPLETE FOR MEMBERS - - AT RISK, LTSS
** Do not complete if member is in E-ARCH***

a) Answer questions for current home/facility
   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/facility. Provide comments as needed, to present a thorough assessment.

c) Answer question regarding interior of home/facility. In the "Other" space, provide information if there are pets in the home/facility and if the home/facility 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 for 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 <u>Attachment for Fall Risk Assessment</u> 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 <u>Tobacco Screener</u>. If response is yes for alcohol use or substance/drug use, complete <u>CAGE-AID Screener.</u>
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 <u>Attachment for Heart Disease and attach to this HFA</u>. If box x is checked, complete <u>Attachment for Asthma/COPD/Respiratory/Tracheostomy/Ventilator</u> 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
☐ 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-F1.10 ATTACHMENT FOR 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)
☐ 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.