STATE OF HAWAII
Special Health Care Needs (SHCN)
ADULT SHCN ASSESSMENT TOOL
18 years and older

SECTION A. ADMINISTRATIVE INFORMATION

A1. Member

a. Member Name

Last First MI

b. Date of Birth
/ /

c. Medicaid ID#

A2. Assessment

a. Reason for Assessment
- ☐ 1. Annual Assessment
- ☐ 2. Discharge Assessment
- ☐ 3. Initial Assessment
- ☐ 4. Reassessment due to a significant change in status
- ☐ 5. Other:

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

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

d. Additional Health Plan
1. Health Plan Name:
2. Subscriber Name:
3. Subscriber Number:

e. Medicare
1. Medicare ☐ Yes ☐ No
2. Medicare Advantage ☐ Yes ☐ No
3. Medicare ID #

f. Other Individual(s) at the Assessment
1. Is there a legal guardian, or representative assisting in the assessment? ☐ Yes ☐ No
2. Name of Individual: Relationship to Member:
3. Name of Individual: Relationship to Member:
4. Name of Individual: Relationship to Member:
5. Name of Individual: Relationship to Member:

A3. Legal Information

a. Legal Responsibility(ies)
- ☐ 1. Self
- ☐ 2. Legal Guardian
  Name:
- ☐ 3. Authorized Representative
  Name:
- ☐ 4. Healthcare Power of Attorney
  Name:
- ☐ 5. Other
  Name:

b. Advance Directives
1. Do you have an Advance Directive? ☐ Yes ☐ No
2. If yes, do you have a copy of the Advance Directive? ☐ Yes ☐ No
3. If no, would you like more information on Advance Directives? ☐ Yes ☐ No
4. Health Plan obtained copy for records ☐ Yes ☐ No
5. Do you have a Physician Orders for Life-Sustaining Treatment (POLST) ☐ Yes ☐ No
6. Location of POLST:

c. Comments:

A4. Emergency Contact(s)

a. Emergency Contact(s)

	Name	Relationship to member	Address	Phone number	Email address
1. Primary					
2. Secondary					

b. Comments:

A5. Long Term Services and Supports (LTSS)

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a. Long Term Services and Supports (LTSS)

1. Do you need companion services? ☐ Yes ☐ No
2. Do you need assistance with chore services? ☐ Yes ☐ No
3. Do you need personal care assistance, i.e., bathing, toileting, etc.? ☐ Yes ☐ No
4. Do you need skilled nursing assistance, i.e., ventilator care, tracheostomy care, enteral feedings, etc.? ☐ Yes ☐ No

b. Comments:

SECTION B. DEMOGRAPHIC INFORMATION

B1. Demographics

a. Gender
- ☐ 1. Male
- ☐ 2. Female

b. Relationship Status
- ☐ 1. Single
- ☐ 2. Married
- ☐ 3. Divorce
- ☐ 4. Separated
- ☐ 5. Widowed
- ☐ 6. Other:

c. Ethnicity
- ☐ 1. African American
- ☐ 2. American Indian or Alaska Native
- ☐ 3. Asian
  - ☐ i. Cambodian
  - ☐ ii. Chinese
  - ☐ iii. Filipino
  - ☐ iv. Indian
  - ☐ v. Japanese
  - ☐ vi. Korean
  - ☐ vii. Laotian
  - ☐ viii. Vietnamese
  - ☐ ix. Other
- ☐ 4. Caucasian
- ☐ 5. Hispanic or Latino
- ☐ 6. Native Hawaiian or other Pacific Islander
  - ☐ i. Federated State of Micronesia
  - ☐ ii. Native Hawaiian
  - ☐ iii. Palauan
  - ☐ iv. Marshallese
  - ☐ v. Samoan
  - ☐ vii. Tongan
  - ☐ vii. Other
- ☐ 7. Other:

B2. Communication

a. Primary Means of Communication ☐ 1. Verbal ☐ 2. Non Verbal ☐ 3. Written ☐ 4. American Sign Language ☐ 5. Other:

b. Primary Spoken Language
- ☐ 1. English
- ☐ 2. Chinese (Cantonese)
- ☐ 3. Chinese (Mandarin)
- ☐ 4. Chuukese
- ☐ 5. Hawaiian
- ☐ 6. Ilocano
- ☐ 7. Japanese
- ☐ 8. Korean
- ☐ 9. Laotian
- ☐ 10. Marshallese
- ☐ 11. Palauan
- ☐ 12. Samoan
- ☐ 13. Spanish
- ☐ 14. Tagalog
- ☐ 15. Tongan
- ☐ 16. Vietnamese
- ☐ 17. Visayan
- ☐ 18. Other:

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

d. Primary Written Language
- ☐ 1. English
- ☐ 2. Braille
- ☐ 3. Chinese (Cantonese)
- ☐ 4. Chinese (Mandarin)
- ☐ 5. Chuukese
- ☐ 6. Hawaiian
- ☐ 7. Ilocano
- ☐ 8. Japanese
- ☐ 9. Korean
- ☐ 10. Laotian
- ☐ 11. Large Format
- ☐ 12. Marshallese
- ☐ 13. Palauan
- ☐ 14. Samoan
- ☐ 15. Spanish
- ☐ 16. Tagalog
- ☐ 17. Tongan
- ☐ 18. Vietnamese
- ☐ 19. Visayan
- ☐ 20. Other:

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

f. Education
1. Education Level:

g. Other Assistive Communication Device(s)
1. Other Assistive Communication Device(s):

h. Comments:

B3. Residence and Living Arrangements

a. Residence

- ☐ 1. Own Private house/apartment
- ☐ 2. Rent Private house/apartment/room
- ☐ 3. Houseless (with or without shelter)
- ☐ 4. Foster Home
- ☐ 5. Rehabilitation hospital/unit
- ☐ 6. Psychiatric hospital/unit
- ☐ 7. Acute care hospital
- ☐ 8. Other:

b. Living Arrangement

- ☐ 1. Alone
- ☐ 2. With spouse/partner only
- ☐ 3. With spouse/partner and other(s)
- ☐ 4. With child (not spouse/partner)
- ☐ 5. With parent(s)/guardian(s)
- ☐ 6. With sibling(s)
- ☐ 7. With other relative(s)
- ☐ 8. With non-relative(s)
- ☐ 9. Other:

c. Comments:

B4. Primary Caregiver

a. Primary Caregiver Status

1. Describe feelings on being a primary caregiver, are you ok?
2. Do you need help caring for member? ☐ Yes ☐ No
3. At what point do you feel you will not be able to care for member and what happens then?
4. Are there any social issues in the home that concerns you? ☐ Yes ☐ No
5. If yes, explain.

b. Comments:

SECTION: C MEDICAL INFORMATION

C1. Disease Diagnosis(es)

a. Disease Diagnosis(es)

List Disease Diagnosis(es)	ICD Code	Date of Onset
		/ /
		/ /
		/ /
		/ /
		/ /

C2. Medications

a. Medications

1. Do you take any medications, e.g., prescribed medications, vitamins, supplements, herbal or OTC medications?
   ☐ Yes ☐ No
2. List Current Medications

Medication Name	Indication	Dose	Route	Frequency	Prescribing Physician/Provider	Compliant	Comments
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	

C3. Treatments and Therap(ies)

a. List Treatment(s) and Therapy(ies)

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

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C4. Medical Equipment and Supplies

a. List Medical Equipment and Supplies

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

C5. Physician(s) and Provider(s)

a. Physician(s) and Provider(s)

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

C6. Utilization of Hospital, Emergency Room, and Physician Services

Services	Date	Reason
a. LAST Inpatient Acute Hospitalization	/ /	
b. LAST Emergency Room visit (not counting overnight stay)	/ /	
c. LAST Physician (or Provider, Practitioner, Authorized Assistant) visit	/ /	

d. Comments:

C7. State Programs

a. State Program(s)

1. Are you currently receiving services from State Program(s)? ☐ Yes ☐ No
2. Identify State Program(s)

	State Program	Contact Name	Phone Number	Number of Service Hours per week
☐	DOE/Special Education			
☐	DOE/Physical, Occupational or Speech Therapy			
☐	DOH/CAMHD			
☐	DOH/AMHD			
☐	DOH/DDD			
☐	DHS/CWS			
☐	DHS/APS			
☐	Other:			

b. Comments:

C8. Prevention

a. Preventive Screening(s)

1. Blood Pressure measured in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
2. Breast Cancer screening in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A

3. Cervical Cancer screening in the LAST YEAR	☐ Yes ☐ No ☐ Unknown ☐ N/A
4. Colorectal screening in the LAST YEAR	☐ Yes ☐ No ☐ Unknown ☐ N/A
5. Osteoporosis in the LAST YEAR	☐ Yes ☐ No ☐ Unknown ☐ N/A
6. Prostate Cancer screening in the LAST 2 YEARS	☐ Yes ☐ No ☐ Unknown ☐ N/A
7. Total Cholesterol measured in the LAST	☐ Yes ☐ No ☐ Unknown ☐ N/A
8. Tuberculin (TB) Skin testing, PPD or 2 Step PPD in the LAST YEAR	☐ Yes ☐ No ☐ Unknown ☐ N/A
9. TB Results Negative/Positive	☐ Negative ☐ Positive
10. TB Date of last Chest X-ray	/ /
11. Weight/Height measured in the LAST YEAR	☐ Yes ☐ No
12. Well member visit/EPSDT screening (18 to 20 years) in the LAST YEAR	☐ Yes ☐ No

b. Comments:

C9. Immunizations

a. Immunizations
1. Are your immunizations up to date? ☐ Yes ☐ No ☐ Unknown
2. Date of Pneumococcal Vaccination / /
3. Date of LAST Influenza Vaccination / /

b. Comments:

C10. Personal Beliefs

a. Personal Beliefs
1. Are there any beliefs and/or concerns that may affect your acceptance of health care assistance, treatments, or procedures? ☐ Yes ☐ No
2. If yes, explain:

b. Comments:

SECTION D. GENERAL HEALTH

D1. Vision, Hearing, Speech, Expression, and Comprehension

a. Vision
1. Visual impairment ☐ Yes ☐ No
   Describe:
2. Has/Uses of corrective lenses or appliances
   i. Glasses ☐ Yes ☐ No
   ii. Contacts ☐ Yes ☐ No
3. Ability to see in adequate light with corrective lenses or appliances
   ☐ i. Adequate ☐ iii. Moderate difficulty
   ☐ ii. Minimal difficulty ☐ iv. Severe difficulty
4. Date of LAST Eye Exam / /

b. Hearing
1. Hearing impairment ☐ Yes ☐ No
   Describe:
2. Has/Uses of hearing aids or appliances
   ☐ Yes ☐ No
3. Ability to hear with hearing aid or appliances
   ☐ i. Adequate ☐ iii. Moderate difficulty
   ☐ ii. Minimal difficulty ☐ iv. Severe difficulty
4. Date of LAST Hearing Exam / /

c. Speech
1. Speech pattern
   ☐ i. Coherent
   ☐ ii. Incoherent
   ☐ iii. No speech
2. Date of LAST Speech Evaluation / /

d. Expression
1. Ability to verbally express ideas
   ☐ i. Understood
   ☐ ii. Usually understood
   ☐ iii. Sometimes understood
   ☐ iv. Rarely or never understood

e. Comprehension
1. Ability to understand others
   ☐ i. Understands
   ☐ ii. Usually understands
   ☐ iii. Sometimes understands
   ☐ iv. Rarely or never understands

f. Comments:

D2. Health Condition

a. Allergies
1. Allergies ☐ Yes ☐ No
2. Specify.

b. Fall History
1. Fall(s) within the last 30 DAYS ☐ Yes ☐ No
2. Fall(s) within the past 31-90 DAYS ☐ Yes ☐ No

c. Pain
1. Communication of Pain
   - ☐ i. Member is verbal and able to answer
   - ☐ ii. Member is non-verbal and unable to answer
   - ☐ iii. Caregiver/Authorized Representative is answering based on observation
2. Current pain ☐ Yes ☐ No
3. Location:
4. Type:
5. Frequency:
6. Intensity:
   - ☐ i. Numeric Rating Scale OR
   - ☐ ii. FACES Pain Rating Scale
7. Break though pain ☐ Yes ☐ No
8. Pain management:

d. Substance Use
1. Tobacco
   - i. Do you use any tobacco products? ☐ Yes ☐ No
   - ii. How often and how many?
   - iii. Does the amount you smoke present any problem(s) for you? ☐ Yes ☐ No
   - iv. If yes, are you interested or willing to quit? ☐ Yes ☐ No
2. Alcohol
   - i. Do you drink any alcohol products? ☐ Yes ☐ No
   - ii. How often and how many?
   - iii. Does the amount you drink present any problem(s) for you? ☐ Yes ☐ No
   - iv. If yes, are you interested or willing to quit? ☐ Yes ☐ No
3. Other Substance
   - i. Do you use any other substance(s)? ☐ Yes ☐ No
   - ii. What substance(s)?
   - iii. How often and how much?
   - iv. Does the amount present any problem(s) for you? ☐ Yes ☐ No
   - v. If yes, are you interested or willing to quit? ☐ Yes ☐ No
3. Have you received treatment for tobacco, alcohol, and/or substance abuse? ☐ Yes ☐ No

e. Comments:

D3. Nutrition

a. Height, Weight, and Body Mass Index (BMI)
1. Height _____ feet _____ inches
   - i. Date of height measurement
     / /
2. Weight _____lbs
   - i. Date of weight measurement
     / /
3. BMI _____
   - i. Date BMI calculated:
     / /

b. Dental
1. Do you have any broken, fragmented, loose, or non-intact natural teeth?
   ☐ Yes ☐ No
2. Do you have/use dentures?
   ☐ Yes ☐ No
3. Are you currently experiencing any tooth aches or pain?
   ☐ Yes ☐ No
4. Date of LAST Dental Exam:
   / /

c. Weight Loss or Gain
1. Describe foods or meals that you normally eat.
2. Has physician or provider recommended a special diet for you? ☐ Yes ☐ No
3. If yes, explain.
4. Has a physician or provider counseled you for your weight? ☐ Yes ☐ No
5. If yes, physician or provider counseled you for weight loss or weight gain? ☐ Loss ☐ Gain

6. Is there a plan for managing your weight? ☐ Yes ☐ No
7. If yes, describe plan.

d. Swallowing
1. Have you ever experienced dry mouth? ☐ Yes ☐ No
2. Do you have difficulty chewing and/or swallowing? ☐ Yes ☐ No
3. If yes, did you have a swallow evaluation? ☐ Yes ☐ No
4. Date of swallow evaluation
5. Do you hold food in your mouth/cheek instead of swallowing? ☐ Yes ☐ No
6. Do you cough or choke during meals or when swallowing medications? ☐ Yes ☐ No

e. Mode of Nutritional Intake
1. Are you able to eat by mouth? ☐ Yes ☐ No
2. Dietary Modifications
   - ☐ i. Normal
   - ☐ ii. Minced
   - ☐ iii. Pureed solids
   - ☐ iv. Thickened liquid

f. Comments:

D4. Musculoskeletal

a. Bones, Muscles, or Joints
1. Do you have any history of bone, muscle, or joint abnormalities or complications? ☐ Yes ☐ No
2. Do you currently have any bone, muscle, or joint abnormalities or complications? ☐ Yes ☐ No
3. Describe your bone, muscle, or joint abnormalities or complications.
4. Have you ever had a bone, muscle, or joint surgery or procedure? ☐ Yes ☐ No
5. Date of Surgery/Procedure and Type.
   Date: / / Type:

b. Comments:

D5. Pregnant Female **(Complete this section if member is a pregnant female)**

a. Pregnant Female Only
1. Expected Date of Delivery / /
2. Date of Last Menstrual Period / /
3. Are you receiving prenatal care? ☐ Yes ☐ No
4. Date of First Prenatal Visit / /
5. Date of Most Recent Prenatal Visit / /
6. Identify your prenatal care provider(s)
   - ☐ i. OB/GYN
   - ☐ ii. Midwife
   - ☐ iii. Other
7. How do you get to your scheduled appointments?
8. Total number of pregnancies:
9. Total number of births:
10. Any history of pregnancy/delivery complications? ☐ Yes ☐ No
11. If yes, explain.
12. Any current complications or is considered a high risk pregnancy? ☐ Yes ☐ No
13. If yes, explain.
14. What are your plans for delivery?
15. What are your plans after delivery?
16. Are you planning on breast feeding? ☐ Yes ☐ No
17. Are there other help after delivery? ☐ Yes ☐ No
18. If yes, explain.

19. Do you have plans for use of birth control after delivery? ☐ Yes ☐ No ☐ Unknown

b. Comments:

SECTION E. DISEASE SPECIFIC QUESTIONS

Instructions: Complete disease specific questions for those that have been identified in Section C1. Disease Diagnosis(es). SC will ask relevant questions appropriate to the member to gather information for SP. For members that have Asthma, COPD, Heart Disease or have a BMI greater than 30, also complete E11. Shortness of Breath.

E1. Asthma

a. Asthma

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

b. Comments:

E2. Cancer

a. Cancer

1. Are you currently being treated for cancer? ☐ Yes ☐ No
2. Type of Cancer.
3. Describe your current status.

b. Comments:

E3. Chronic Obstructive Pulmonary Disorder (COPD)

a. COPD

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

16. Oxygen Flow rate _____ LPM
17. Mode of oxygen delivery.

b. Comments:

E4. Diabetes

a. Diabetes

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

b. Comments:

E5. End Stage Renal Disease (ESRD)

a. ESRD

1. When were you diagnosed with renal failure? / /
2. Are you currently receiving dialysis? If yes, complete the following questions:
   i. Facility Name:
   ii. Location:
   iii. Telephone:
3. What type of dialysis is currently being used?
   ☐ i. Peritoneal
   ☐ ii. Hemodialysis
   ☐ iii. Other:
4. If peritoneal, who is assisting with your dialysis?
5. Dialysis frequency
   ☐ i. Daily
   ☐ ii. Three times per week
   ☐ iii. Other:
6. Current access type for dialysis
   ☐ i. AV Fistula
   ☐ ii. AV Graft
   ☐ iii. Vas Cath

7. Site most used
   - ☐ i. AV Fistula
   - ☐ ii. AV Graft
   - ☐ iii. Vas Cath
8. Have you missed 1 or more dialysis appointments in the last 30 days? ☐ Yes ☐ No
9. If yes, explain.
10. How do you get to your dialysis appointment?
11. Do you have help after your dialysis treatments?
12. Do you experience any problem(s) with your dialysis treatments? ☐ Yes ☐ No
13. If yes, explain.

b. Comments:

E6. Heart Disease

a. Heart disease

1. Do you have a heart condition? ☐ Yes ☐ No
   If yes, explain.
2. Have you had any heart surgeries? ☐ Yes ☐ No
3. If yes, what are the type(s) and dates of your heart procedure(s), e.g., valve surgery, catheterization.
   Heart Procedure: Date: / /
   Heart Procedure: Date: / /
4. Have you experienced any of the following (Select all that apply)
   - ☐ 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 relieved with rest
   - ☐ viii. Stroke
5. Do you get tired easily when walking short distances or walking up or down stairs? ☐ Yes ☐ No
6. How do you know that your heart condition is getting worse (i.e., weight gain, shortness of breath, swelling of lower extremities, facial droop, aphasia, angina, lightheadedness, etc.)
7. Do you regularly check your weight? ☐ Yes ☐ No
8. Do you regularly check your blood pressure? ☐ Yes ☐ No
9. Do you regularly check your pulse? ☐ Yes ☐ No

b. Comments:

E7. Hepatitis B/C

a. Hepatitis B/C

1. Briefly describe your current symptoms related to your condition.
2. Are you experiencing any side effects from the medications? ☐ Yes ☐ No
3. Do you have any help? ☐ Yes ☐ No
4. Do you need further help? ☐ Yes ☐ No
5. If no, do you anticipate needing help in the future? ☐ Yes ☐ No
6. Are you able to travel to your schedule doctor appointments? ☐ Yes ☐ No

b. Comments:

E8. High Blood Pressure

a. High blood pressure

1. Briefly describe your current symptoms related to your high blood pressure.
2. Do you currently monitor your blood pressure levels? ☐ Yes ☐ No

3. How often is blood pressure being monitored?
4. Has your doctor set a goal for your blood pressure range? ☐ Yes ☐ No
5. What is your doctor's recommended blood pressure range? _____-_____
6. Is there a plan in place for managing blood pressure? ☐ Yes ☐ No
7. If yes, explain.
8. Do you have high blood sugar, kidney or circulatory problems? ☐ Yes ☐ No
9. If yes, explain.
10. List current symptoms that would indicate that your high blood pressure is getting worse (i.e., chest pressure/discomfort, shortness of breath, headache etc.)
11. Are you able to list your symptoms? ☐ Yes ☐ No

b. Comments:

E9. HIV/AIDS

a. HIV/AIDS

1. Identify the current stage of your disease (HIV/AIDS)
   - ☐ i. Acute Infection
   - ☐ ii. Clinical latency (inactivity or dormancy)
   - ☐ iii. AIDS
   - ☐ iv. Unknown
2. Briefly describe your current symptoms related to your condition.
3. Experiencing any side effects from the medications? ☐ Yes ☐ No
4. Do you have any help? ☐ Yes ☐ No
5. Do you need further help? ☐ Yes ☐ No
6. If no, do you anticipate needing help in the future? ☐ Yes ☐ No
7. Are you able to travel to your scheduled doctor appointments? ☐ Yes ☐ No

b. Comments:

E10. Seizures

a. Seizures

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

b. Comments:

E11. Shortness of Breath (Complete this section if member has Asthma, COPD, Heart Disease or BMI over 3.0)

a. Shortness of breath

1. How would you describe your shortness of breath, e.g., mild, moderate, severe.
2. When do you experience shortness of breath?

3. What relieves your shortness of breath?
4. Is there a plan in place for managing your shortness of breath? ☐ Yes ☐ No
5. If yes, explain.

b. Comments:

E12. Transplant

a. Transplant
1. Have you had a transplant? ☐ Yes ☐ No
2. What type of transplant:
3. Describe your current status.

b. Comments:

SECTION F. TRANSPORTATION

a. Assessor Determination
1. Is the member alert and aware of surroundings? ☐ Yes ☐ No
2. Is the member able to understand and respond to verbal commands? ☐ Yes ☐ No

b. Transportation
1. Current Mode of Transportation (Select all that apply)
   - ☐ i. Drives own vehicle
   - ☐ ii. Family or friends
   - ☐ iii. Public transportation
     - ☐ a. Bus
     - ☐ b. Handi van
   - ☐ iv. Van
     - ☐ a. Curb to curb
     - ☐ b. Door to door
     - ☐ c. Gurney
   - ☐ v. Taxi
   - ☐ vi. Air Travel for specialist care
   - ☐ vii. Other:
2. Are you able to use public transportation or can someone regularly transport you to obtain medical services? ☐ Yes ☐ No
3. If no, explain.
4. Are you able to ambulate without assistance (with or without device, to include wheelchair)? ☐ Yes ☐ No
5. Are you able to ambulate to the local bus stop (both house and medical appointments)? ☐ Yes ☐ No
6. Describe.
7. If wheelchair bound, are you able to self-propel to curb side for pick up? ☐ Yes ☐ No
8. If wheelchair bound, are you able to transfer in and out of vehicle without assistance? ☐ Yes ☐ No
9. If the member needs assistance, do you have an attendant? ☐ Yes ☐ No
10. Does the member require any medical equipment when traveling? ☐ Yes ☐ No
11. If yes, list medical equipment (e.g., oxygen, etc.)
12. Reason member is unable to get to curb side alone (Select all that apply)
    - ☐ i. No attendant
    - ☐ ii. Attendant is unable to help member to curb side
    - ☐ iii. Member is non ambulatory
    - ☐ iv. Member is unable to transfer or receive assistance

c. Comments:

SECTION F. MEMBER NEEDS

SC will use this section to identify member needs.

F1. Treatments and Therapy Needs

a. List Treatment and Therapy Needs

Treatment/Therapy	Frequency	Comments

F2. Medical Equipment and Supply Needs

a. List Medical Equipment and Supply Needs

Medical Equipment/Supply	Type/Description	Comments

F3. Referrals

a. Referrals

Service	Comments

SECTION G. EDUCATION

a. List Education

Education that was Provided	Education Needs	Comments

SECTION H. SUMMARY/ADDITIONAL INFORMATION

a. Instructions: Provide a brief summary of visit. Include additional information that affects the delivery of services i.e., any barriers and identify any needs that require follow up.

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
16. Oxygen concentrator

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	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 5. Counseling and Training 6. Community Care Foster Family Home (CCFFH)/Expanded Adult Residential Care Home (E-ARCH) 7. Environmental Accessibility Adaptations (EAA) 8. Home Delivered Meals	9. Home Maintenance 10. Moving Assistance 11. Non-Medical Transportation 12. Personal Assistance Services – Level I (PA I) 13. Personal Assistance Services – Level II (PA II) 14. Personal Assistance- Level II (Delegated) (PA II-Delegated) 15. Personal Emergency Response Systems (PERS) 16. Respite Care 17. Skilled (or private duty) Nursing (SN) 18. 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. Seizures 11. Shortness of Breath 12. Transplant 99. Other
Appendix F. Acronyms	
1. **ADC** Adult Day Care 2. **ADH** Adult Day Health 3. **ADLs** Activities of Daily Living 4. **ALF** Assisted Living Facility 5. **AMHD** Adult Mental Health Division 6. **APS** Adult Protective Services 7. **ARCH** Adult Residential Care Home 8. **ASL** American Sign Language 9. **BMI** Body Mass Index 10. **CAMHD** Child and Adolescent Mental Health Division 11. **CCFFH** Community Care Foster Family Home	18. **EAA** Environmental Accessibilities Adaptations 19. **E-ARCH** Expanded Adult Residential Care Home 20. **EPSDT** Early and Periodic Screening, Diagnosis, and Treatment 21. **HCBS** Home and Community Based Services 22. **IADLs** Instrumental Activities of Daily Living 23. **ICF** Intermediate Care Facility 24. **LTSS** Long-Term Services and Supports 25. **MQD** Med-QUEST Division 26. **NF** Nursing Facility 27. **PA** Personal Assistant 28. **PERS** Personal Emergency Response System

12. **CCMA** Community Care Management Agency	29. **PCP** Primary Care Provider
13. **CWS** Child Welfare Services	30. **SC** Service Coordinator
14. **DDD** Developmental Disabilities Division	31. **SHCN** Special Health Care Needs
15. **DHS** Department of Human Services	32. **SN** Skilled Nursing (Private Duty)
16. **DOE** Department of Education	33. **SNAP** Supplemental Nutrition Assistance Program
17. **DOH** Department of Health	34. **SNF** Skilled Nursing Facility
	35. **SP** Service Plan