STATE OF HAWAII
Long Term Services and Support (LTSS)
CHILD LTSS REASSESSMENT TOOL
Up through 17 years old

Instructions: *Compile information from health plan records and address changes from previous assessment. Refer to CHILD LTSS ASSESSMENT INSTRUCTIONS for information on completing the appropriate sections. If there are no changes, check box "No Changes"*

SECTION A. ADMINISTRATIVE INFORMATION

A1. Member

a. Member Name	b. Date of Birth	c. Medicaid ID#
Last First MI	/ /	

A2. Assessment

a. Reason for Assessment
1. HCBS Reassessment
   - ☐ Three (3) months
   - ☐ Six (6) months
   - ☐ Nine (9) months
2. NF Reassessment
   - ☐ Six (6) months

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

c. Assessor
1. Assessor Name:
2. Title:

e. Individual(s) at the Assessment
1. Name of Individual: Relationship to Member:
2. Name of Individual: Relationship to Member:
3. Name of Individual: Relationship to Member:
4. Name of Individual: Relationship to Member:

A3. Legal Information ☐ No Changes

Comments:

SECTION B. DEMOGRAPHIC INFORMATION

Comments:

SECTION. C MEDICAL INFORMATION

C1. Disease Diagnosis(es) ☐ No Changes

a. Disease Diagnosis(es)

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

C2. Medications ☐ No Changes

a. Medications
1. Do you take any medications, i.e.., 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. Treatment(s) and Therapy(ies) ☐ No Changes

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

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

C4. Medical Equipment and Supplies ☐ No Changes

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. HCBS Services ☐ No Changes

a. List HCBS Services

HCBS Service	Provider/Agency	Frequency	Comments

C6. Institutional Services ☐ No Changes

a. List Institutional Services

Institution Service	Provider	Comments

C7. Physician(s) and Provider(s) ☐ No Changes

a. Physician(s) and Provider(s)

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

C8. Utilization of Hospital, Emergency Room, and Physician Services ☐ No Changes

Comments:

C9. State Programs ☐ No Changes

*****Do not complete for NF*****

Comments:

SECTION D. PERSON CENTERED INFORMATION

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D1. Social Supports ☐ No Changes

*****Do not complete for NF*****

a. Social Supports

1. Family and/or friends living in the SAME residence

Name	Age	Relationship	Cell Phone	Day/Hours NOT available	Type of help	# of hours helped in LAST 7 days	Paid	Employed	Employer	Work hours/ week
							☐ Yes ☐ No	☐ Yes ☐ No		
							☐ Yes ☐ No	☐ Yes ☐ No		
							☐ Yes ☐ No	☐ Yes ☐ No		

2. Family and/or friends NOT living in the same residence and providing support to member

Name	Age	Relationship	Cell Phone	Day/Hours NOT available	Type of help	# of hours helped in LAST 7 days	Paid	Employed	Employer	Work hours/ week
							☐ Yes ☐ No	☐ Yes ☐ No		
							☐ Yes ☐ No	☐ Yes ☐ No		
							☐ Yes ☐ No	☐ Yes ☐ No		

b. Comments:

D2. Parents/Primary Caregiver ☐ No Changes

*****Do not complete for NF*****

a. Parents/Primary Caregiver Status

1. Describe your feelings, are you ok?
2. Describe how you take care of yourself.
3. Rate your overall general health and psychological well-being
   - ☐ i. Good
   - ☐ ii. Fair
   - ☐ iii. Poor
4. Do you need help caring for member? ☐ Yes ☐ No
5. At what point do you feel you will not be able to care for member and what happens then?
6. Are there any social issues in the home that concerns you? ☐ Yes ☐ No
7. If yes, explain.
8. Do you have other demands or responsibilities? ☐ Yes ☐ No
9. If yes, explain.

b. Comments:

SECTION E. GENERAL HEALTH

E1. Mood, Behavior, and Psychological Well Being ☐ No Changes

Note: If member scores 15 or higher on Pediatric Symptom Checklist or answers yes to questions b or c, SC should refer member to PCP or CAMHD for further evaluation.

a. 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	☐	☐	☐
Score:			

b.
1. Does your child have any emotional or behavioral problems for which she/he needs help? ☐ Yes ☐ No
2. If yes, please explain and place comments here.

c.
1. Has anything significant happened recently that impacts your child's life? ☐ Yes ☐ No
2. If yes, please identify and place comments here.

d. Comments:

E2. Functional Status ☐ No Changes

a. Activities of Daily Living (ADLs)

	Independent	Minimal	Moderate	Total
1. Eating/Feeding	☐	☐	☐	☐
2. Bathing	☐	☐	☐	☐
3. Dressing upper body	☐	☐	☐	☐
4. Dressing lower body	☐	☐	☐	☐
5. Grooming/Personal hygiene	☐	☐	☐	☐
6. Toileting	☐	☐	☐	☐
7. Walks with our without assistive device Identify assistive device(s):	☐	☐	☐	☐
8. Ambulation/Locomotion	☐	☐	☐	☐
9. Do you have difficulty accessing areas of your house? ☐ Yes ☐ No	If yes, explain.			
10. Transfers	☐	☐	☐	☐
11. Medication assistance	☐	☐	☐	☐

b. Activity and Mobility (if appropriate)
1. Are you able to engage in moderate physical Activity? ☐ Yes ☐ No
2. How many days per week?
3. How many total hours per week?
4. Are there any physical limitations and/or environmental barriers that make it difficult for you to engage in physical activities? ☐ Yes ☐ No
5. If yes, explain.
6. Do you feel that you are capable of increasing physical activity? ☐ Yes ☐ No
7. If yes or no, explain.

c. Comments:

E3. Health Condition ☐ No Changes

a. Vitals
(Obtain only if Primary SC is an RN)
1. Temperature _____ F
   i. Mode
2. Pulse _____ bpm
   i. Mode
3. Respirations _____ per min
4. Oxygen Saturation _____%
   i. Mode
5. Blood Pressure _____/_____
   i. Location:
   ii. Position:
   iii. Usual blood pressure range
   - / -

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. Comments:

E4. Continence ☐ No Changes

a. Continence
1. Bladder Continence
   ☐ 1. Continent
   ☐ 2. Control with catheter or ostomy
   ☐ 3. Incontinent
2. Bowel Continence
   ☐ 1. Continent
   ☐ 2. Control with ostomy
   ☐ 3. Incontinent

b. Do you use any incontinence products?
☐ Yes ☐ No

c. Comments:

E5. Skin ☐ No Changes

a. Skin
1. Do you have any history of skin breakdown or pressure sores? ☐ Yes ☐ No
2. Do you currently have any skin break down, tears, or open sores? ☐ Yes ☐ No
3. Do you have any blood, drainage, or odor from a wound? ☐ Yes ☐ No
4. Describe the wound(s) and location(s).

b. Comments:

E6. Pregnant Female (Assess only if applicable) ☐ No Changes

*****Do not complete for NF*****

Comments:

SECTION F. TRANSPORTATION ☐ No Changes

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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. Family vehicle
   - ☐ ii. Friend's vehicle
   - ☐ 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. Able to use public transportation or someone regularly transports you to medical services? ☐ Yes ☐ No
3. If no, explain.
4. Able to ambulate without assistance (with or without device, to include wheelchair)? ☐ Yes ☐ No
5. Able to ambulate to the local bus stop (both house and medical appointments)? ☐ Yes ☐ No
6. If no, explain.
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. Requires a nurse for medical appointments.
10. If the member needs assistance, do you have an attendant? ☐ Yes ☐ No
11. Does the member require any medical equipment when traveling? ☐ Yes ☐ No
12. If yes, list medical equipment (e.g., ventilator, suction machine, feeding pump, etc.)
13. Reason member is unable to get to curb side alone (Select all that apply)
    - ☐ i. Attendant is unable to help member to curb side
    - ☐ ii. Member is bedbound
    - ☐ iii. Member is non ambulatory
    - ☐ iv. Member is unable to transfer or receive assistance

c. Comments:

SECTION G. EMERGENCY PLANNING ☐ No Changes

Comments:

SECTION H. MEMBER NEEDS ☐ No Changes

Refer to: ☐ 1. Social Worker ☐ 2. Nurse

SECTION I. SUMMARY/ADDITIONAL INFORMATION ☐ No Changes

Document, at a minimum, the following:

1. Status of all items on the service plan
2. Changes for areas identified on this tool
3. Update on all disease specific conditions of the member
4. Any concerns related to home environment
5. Any changes related to emergency planning
6. Any reference to other service coordinator consultants (i.e., nurse or social worker)
7. Any other pertinent areas that SC identified upon reassessment

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J. HOME ENVIRONMENT ASSESSMENT

a. Current Home

1. Currently Living In (Select all that apply)
   - ☐ i. Own House
   - ☐ ii. Own Apartment
   - ☐ iii. Rented House
   - ☐ iv. Rented Apartment
   - ☐ v. Section 8
   - ☐ vi. Public Housing
   - ☐ vii. Hawaiian Homestead
   - ☐ viii. Relative/Friend's House
   - ☐ ix. Other:
2. Does the neighborhood appear safe? ☐ Yes ☐ No
3. Does the building have a secured lobby? ☐ Yes ☐ No
4. If yes, entry code and/or entry directions.
5. Is there an elevator in the building? ☐ Yes ☐ No
6. Is the home accessible to wheelchairs or other assistive devices? ☐ Yes ☐ No
7. Accessible Locations (Select all that apply)
   - ☐ i. Doorways
   - ☐ ii. Hallway
   - ☐ iii. Bathroom
   - ☐ iv. Exits

	Adequate	Inadequate	N/A	Comments
b. Exterior Assessment				
Walkways free of clutter	☐	☐	☐	
Ramps/handrails safe	☐	☐	☐	#Exits ☐ Accessible Locations
Stairs safe	☐	☐	☐	#steps Locations
Safe water source	☐	☐	☐	Water catchment
Other:	☐	☐	☐	
c. Interior Assessment				
Clear pathway to exit/entry	☐	☐	☐	
Sturdy floors (other structural)	☐	☐	☐	
Handrails safe	☐	☐	☐	
Stairs safe	☐	☐	☐	#steps Locations
Free of trash accumulation/Trash Disposal	☐	☐	☐	
Lighting	☐	☐	☐	
Tacked down rugs and carpets	☐	☐	☐	
Visible cords/electrical circuits safe	☐	☐	☐	
Telephone service and accessibility	☐	☐	☐	
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	☐	☐	☐	
Cooking appliances safe	☐	☐	☐	☐ Stove ☐ Fridge ☐ Freezer ☐ Microwave
Food storage safe	☐	☐	☐	
Pets in house (cats, dogs, etc.) secured	☐	☐	☐	
Laundry	☐	☐	☐	☐ Washer ☐ Dryer
Insects/other pests or rodents	☐	☐	☐	
Smoke free house	☐	☐	☐	
Guns/weapons (locked/unlocked)	☐	☐	☐	
Sufficient space for equipment/supplies	☐	☐	☐	☐ Generator
Home ventilation	☐	☐	☐	☐ Too hot ☐ Too cold
Other:	☐	☐	☐	