

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

**SECTION A. ADMINISTRATIVE INFORMATION**

**A1. Member**

a. Member Name  <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black; margin-bottom: 5px;"> <span style="width: 30%;">Last</span> <span style="width: 30%;">First</span> <span style="width: 30%;">MI</span> </div>	b. Date of Birth  <div style="text-align: center; border-bottom: 1px solid black; margin-bottom: 5px;">       / /     </div>	c. Medicaid ID#
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**A2. Assessment**

a. Reason for Assessment <input type="checkbox"/> 1. Annual Assessment <input type="checkbox"/> 2. Discharge Assessment <input type="checkbox"/> 3. Initial Assessment <input type="checkbox"/> 4. Reassessment due to a significant change in status <input type="checkbox"/> 5. Other:	b. Assessment Reference Date <input type="checkbox"/> 1. Date / / <input type="checkbox"/> 2. Time __:__ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> 3. Location: <input type="checkbox"/> 4. Identify any safety issues that a SC may encounter during the assessment.
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c. Assessor 1. Assessor Name: 2. Title:	d. Additional Health Plan 1. Health Plan Name: 2. Subscriber Name: 3. Subscriber Number:
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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**

a. Legal Responsibility(ies) <input type="checkbox"/> 1. Legal Guardian Name: <input type="checkbox"/> 2. Authorized Representative Name: <input type="checkbox"/> 3. Healthcare Power of Attorney Name: <input type="checkbox"/> 4. Other Name: <input type="checkbox"/> 5. Identify parents or adults who are NOT allowed information on the member, only if identified on a legal document.	b. Advance Directives 1. Do you have an Advance Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. If yes, do you have a copy of the Advance Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. If no, would you like more information on Advance Directives? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Health Plan obtained copy for records <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Do you have a Physician Orders for Life-Sustaining Treatment (POLST) <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Location of POLST:
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c. Comments:

**SECTION B. DEMOGRAPHIC INFORMATION**

**B1. Demographics**

a. Gender  
 1. Male  
 2. Female

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**b. Ethnicity**

1. African American

2. American Indian or Alaska Native

3. Asian

i. Cambodian       iv. Indian       vii. Laotian

ii. Chinese       v. Japanese       viii. Vietnamese

iii. Filipino       vi. Korean       ix. Other

4. Caucasian

5. Hispanic or Latino

6. Native Hawaiian or other Pacific Islander

i. Federated State of Micronesia       v. Samoan

ii. Native Hawaiian       vii. Tongan

iii. Palauan       viii. Other

iv. Marshallese

7. Other:

**B2. Communication**

**a. Primary Means of Communication**       1. Verbal       3. Written       5. Other:

2. Non Verbal       4. American Sign Language

<p><b>b. Primary Spoken Language</b></p> <p><input type="checkbox"/> 1. English      <input type="checkbox"/> 7. Japanese      <input type="checkbox"/> 13. Spanish</p> <p><input type="checkbox"/> 2. Chinese (Cantonese)      <input type="checkbox"/> 8. Korean      <input type="checkbox"/> 14. Tagalog</p> <p><input type="checkbox"/> 3. Chinese (Mandarin)      <input type="checkbox"/> 9. Laotian      <input type="checkbox"/> 15. Tongan</p> <p><input type="checkbox"/> 4. Chuukese      <input type="checkbox"/> 10. Marshallese      <input type="checkbox"/> 16. Vietnamese</p> <p><input type="checkbox"/> 5. Hawaiian      <input type="checkbox"/> 11. Palauan      <input type="checkbox"/> 17. Visayan</p> <p><input type="checkbox"/> 6. Ilocano      <input type="checkbox"/> 12. Samoan      <input type="checkbox"/> 18. Other:</p>	<p><b>c. Interpretation</b></p> <p>1. Do you need an interpreter?</p> <p style="text-align: center;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
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<p><b>d. Primary Written Language</b></p> <p><input type="checkbox"/> 1. English      <input type="checkbox"/> 8. Japanese      <input type="checkbox"/> 15. Spanish</p> <p><input type="checkbox"/> 2. Braille      <input type="checkbox"/> 9. Korean      <input type="checkbox"/> 16. Tagalog</p> <p><input type="checkbox"/> 3. Chinese (Cantonese)      <input type="checkbox"/> 10. Laotian      <input type="checkbox"/> 17. Tongan</p> <p><input type="checkbox"/> 4. Chinese (Mandarin)      <input type="checkbox"/> 11. Large Format      <input type="checkbox"/> 18. Vietnamese</p> <p><input type="checkbox"/> 5. Chuukese      <input type="checkbox"/> 12. Marshallese      <input type="checkbox"/> 19. Visayan</p> <p><input type="checkbox"/> 6. Hawaiian      <input type="checkbox"/> 13. Palauan      <input type="checkbox"/> 20. Other:</p> <p><input type="checkbox"/> 7. Ilocano      <input type="checkbox"/> 14. Samoan</p>	<p><b>e. Translation</b></p> <p>1. Do you need a translator?</p> <p style="text-align: center;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
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<p><b>f. Education</b></p> <p>1. Education Level:</p>	<p><b>g. Other Assistive Communication Device(s)</b></p> <p>1. Other Assistive Communication Device(s):</p>
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**h. Comments:**

**B3. Residence and Living Arrangements**

**a. Residence**

<input type="checkbox"/> 1. Own Private house/apartment	<input type="checkbox"/> 6. Rehabilitation hospital/unit
<input type="checkbox"/> 2. Rent Private house/apartment/room	<input type="checkbox"/> 7. Psychiatric hospital/unit
<input type="checkbox"/> 3. Houseless (with or without shelter)	<input type="checkbox"/> 8. Acute care hospital
<input type="checkbox"/> 4. Foster Home	<input type="checkbox"/> 9. Other:
<input type="checkbox"/> 5. Nursing Facility (NF)	

**b. Living Arrangements**

<input type="checkbox"/> 1. With parent(s)/guardian(s)	<input type="checkbox"/> 4. With non-relative(s)
<input type="checkbox"/> 2. With sibling(s)	<input type="checkbox"/> 5. Other:
<input type="checkbox"/> 3. With other relative(s)	

**c. Comments:**

**SECTION. C MEDICAL INFORMATION**

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<b>C1. Disease Diagnosis(es)</b>							
a. Disease Diagnosis(es)							
List Disease Diagnosis(es)	ICD Code			Date of Onset			
				/ /			
				/ /			
				/ /			
				/ /			
				/ /			
<b>C2. Medications</b>							
a. Medications							
1. Do you take any medications, i.e., prescribed medications, vitamins, supplements, herbal or OTC medications?							
<input type="checkbox"/> Yes <input type="checkbox"/> No							
2. List Current Medications							
Medication Name	Indication	Dose	Route	Frequency	Prescribing Physician/Provider	Compliant	Comments
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>C3. Treatment(s) and Therapy(ies)</b>							
a. List Treatment(s) and Therapy(ies)							
Treatment/Therapy	Prescribing Physician/Provider	Provider/Agency	Frequency	Comments			
<b>C4. Medical Equipment and Supplies</b>							
a. List Medical Equipment and Supplies							
Medical Equipment and Supplies	Type/Description	Prescribing Physician/Provider	Indicate Rent or Own	Vendor and Phone Number	Comments		
			<input type="checkbox"/> Rent <input type="checkbox"/> Own				
			<input type="checkbox"/> Rent <input type="checkbox"/> Own				
			<input type="checkbox"/> Rent <input type="checkbox"/> Own				
			<input type="checkbox"/> Rent <input type="checkbox"/> Own				
			<input type="checkbox"/> Rent <input type="checkbox"/> Own				
<b>C5. HCBS Services</b>							
a. List HCBS Services							
HCBS Service	Provider/Agency	Frequency	Comments				
<b>C6. Institutional Services</b>							
a. List Institutional Services							
Institution Service	Provider	Comments					

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**C7. Physician(s) and Provider(s)**

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**

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:		

**C9. State Programs**

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

a. State Program(s)

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

2. Identify the State Program(s):

	State Program	Contact Name	Phone Number	Number of Service Hours per week
<input type="checkbox"/>	DOE/Special Education			
<input type="checkbox"/>	DOE/Physical, Occupational or Speech Therapy			
<input type="checkbox"/>	DOH/CAMHD			
<input type="checkbox"/>	DOH/DDD			
<input type="checkbox"/>	DHS/CWS			
<input type="checkbox"/>	Other:			

b. Comments:

**C10. Prevention**

a. Prevention

1. LAST EPSDT screening	/ /	
2. LAST Well Child visit	/ /	
3. Pap Smear (for sexually active) in the LAST YEAR	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	
4. Total Cholesterol measured in the LAST YEAR	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	
5. Tuberculin (TB) Skin testing, PPD or 2 Step PPD in the LAST YEAR	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	
6. TB Results Negative/Positive	<input type="checkbox"/> Negative <input type="checkbox"/> Positive	
7. Date of last TB Chest X-ray	/ /	

b. Comments:

**C11. Immunizations**

a. Immunizations

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1. Are your immunizations up to date?  Yes  No  
 2. Date of LAST Influenza Vaccination / /

b. Comments:

**C12. Personal Beliefs**

a. Personal Beliefs  
 1. Do you have 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. PERSON CENTERED INFORMATION**

**D1. Personal Interview**

a. Personal Interview

- Describe a "good day" for you.
- Describe a "bad day" for you.
- Describe ongoing responsibilities that you have to take care of.
- What are your strengths and accomplishments?
- What are your needs and concerns?

	6. Describe your life now.	7. Describe what you want in life.
Home/Family		
Recreation /Fun/Relaxation		
Community Involvement/ Social/Religious/Culture		

8. Do you have any specific end of life wishes or arrangements?  Yes  No  
 9. If yes, describe.

b. Comments:

**D2. Finances**

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

a. Finances  
 1. Are you able to pay for your major monthly expenses?  Yes  No  
 2. If no, explain.  
 3. Are you receiving financial assistance?  Yes  No  
 4. Are you receiving SNAP?  Yes  No

b. Comments:

**D3. Social Supports**

**\*\*\*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
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

3. Strong and supportive relationship with family?  Yes  No

b. Comments:

**D4. Parents/Primary Caregiver**

**\*\*\*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. Birth History**

a. Birth History

1. Did your mother have any problems while she was pregnant with you?  Yes  No
2. If yes, describe.
3. Did you have any problems when you were born?  Yes  No
4. If yes, describe.
5. Did you have to stay in the Intensive Care Unit (ICU) after you were born?  Yes  No
6. If yes, describe.

b. Comments:

**E2. Vision, Hearing, Speech, Expression and Comprehension**

<p>a. Vision</p> <ol style="list-style-type: none"> <li>1. Visual impairment <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:</li> <li>2. Has/Uses corrective lenses or appliance           <ul style="list-style-type: none"> <li>i. Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>ii. Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> </li> <li>3. Ability to see in adequate light with corrective lenses or appliance           <ul style="list-style-type: none"> <li><input type="checkbox"/> i. Adequate <input type="checkbox"/> iii. Moderate difficulty</li> <li><input type="checkbox"/> ii. Minimal difficulty <input type="checkbox"/> iv. Severe difficulty</li> </ul> </li> <li>4. Date of LAST Eye Exam / /</li> </ol>	<p>b. Hearing</p> <ol style="list-style-type: none"> <li>1. Hearing impairment <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:</li> <li>2. Has/Uses hearing aids or appliance <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>3. Ability to hear with hearing aid or appliance           <ul style="list-style-type: none"> <li><input type="checkbox"/> i. Adequate <input type="checkbox"/> iii. Moderate difficulty</li> <li><input type="checkbox"/> ii. Minimal difficulty <input type="checkbox"/> iv. Severe difficulty</li> </ul> </li> <li>4. Date of LAST Hearing Exam / /</li> </ol>
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<p>c. Speech</p> <ol style="list-style-type: none"> <li>1. Speech pattern           <ul style="list-style-type: none"> <li><input type="checkbox"/> i. Coherent</li> <li><input type="checkbox"/> ii. Incoherent</li> </ul> </li> </ol>	<p>d. Expression</p> <ol style="list-style-type: none"> <li>1. Ability to verbally express ideas           <ul style="list-style-type: none"> <li><input type="checkbox"/> i. Understood</li> <li><input type="checkbox"/> ii. Usually understood</li> </ul> </li> </ol>	<p>e. Comprehension</p> <ol style="list-style-type: none"> <li>1. Ability to understand others           <ul style="list-style-type: none"> <li><input type="checkbox"/> i. Understands</li> <li><input type="checkbox"/> ii. Usually understands</li> </ul> </li> </ol>
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<input type="checkbox"/> iii. No speech 2. Date of LAST Speech Evaluation / /	<input type="checkbox"/> iii. Sometimes understood <input type="checkbox"/> iv. Rarely or never understood	<input type="checkbox"/> iii. Sometimes understands <input type="checkbox"/> iv. Rarely or never understands
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f. Comments:

**E3. Developmental Milestones**

a. Developmental Milestones

1. Infancy (Birth – 12 months)
  - i. Recognizes familiar people.  Yes  No
  - ii. Follows objects with eyes both in same direction.  Yes  No
  - iii. Pull to a standing position.  Yes  No
  - iv. Know approx. five or six words.  Yes  No
2. Toddler (1-3 years)
  - i. Developing autonomy by becoming more independent and involved in self-care.  Yes  No
  - ii. Spontaneously shows affection for familiar playmates, family and other familiar people.  Yes  No
  - iii. Using or formulating sentence structure in their speech.  Yes  No
  - iv. Able to walk up stairs and/or open a door.  Yes  No
3. Preschool (3-6 years)
  - i. Developing mastery over movement and play.  Yes  No
  - ii. Fantasizes and developing fears.  Yes  No
  - iii. Developing ability to make choices.  Yes  No
4. School (6-12 years)
  - i. Follows rules and likes to do things the “right way.”  Yes  No
  - ii. Enjoys school and peers.  Yes  No
  - iii. Have supportive adults in their lives.  Yes  No
5. Adolescence (12-18 years)
  - i. Able to think abstractly/logical thought and deductive reasoning.  Yes  No
  - ii. Concerns about looking and being different from others.  Yes  No
  - iii. Ability to make choices and have control.  Yes  No

**E4. Mood, Behavior, and Psychological Well Being**

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feels hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Dislikes themselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Worries a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Seems to be having less fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Fidgety, unable to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Daydreams too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Distracted easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Acts as if they have endless energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Fights with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does not listen to rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Does not care about others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Teases others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Blames others for his/her troubles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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16. Does not like to share	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Takes things that do not belong to him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b. Score:

c.

1. Does your child have any emotional or behavioral problems for which she/he needs help?  Yes  No

2. If yes, please explain.

d.

1. Has anything significant happened recently that impacts your child's life?  Yes  No

2. If yes, please identify.

e. Comments:

**E5. Functional Status**

a. Activities of Daily Living (ADLs)

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

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:

**E6. Health Condition**

<p>a. Vitals</p> <p>1. Temperature ____ F</p> <p style="padding-left: 20px;">i. Mode</p> <p>2. Pulse ____ bpm</p> <p style="padding-left: 20px;">i. Mode</p> <p>3. Respirations ____ per min</p> <p>4. Oxygen Saturation ____%</p> <p style="padding-left: 20px;">i. Mode</p> <p>5. Blood Pressure ____/____</p> <p style="padding-left: 20px;">i. Location:</p> <p style="padding-left: 20px;">ii. Position:</p> <p style="padding-left: 20px;">iii. Usual blood pressure range</p> <p style="padding-left: 40px;">- / -</p>	<p>b. Allergies</p> <p>1. Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Specify.</p> <hr/> <p>c. Fall History</p> <p>1. Fall(s) within the last 30 DAYS</p> <p style="padding-left: 20px;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Fall(s) within the past 31-90 DAYS</p> <p style="padding-left: 20px;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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d. Pain

1. Communication of Pain



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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 through pain  Yes  No

8. Pain management:

e. Comments:

**E7. Nutrition**

<p>a. Height, Weight, and Body Mass Index (BMI)</p> <p>1. Height _____ feet _____ inches          i. Date of height measurement             / /</p> <p>2. Weight _____ lbs          i. Date of weight measurement             / /</p> <p>3. BMI Calculation _____          i. Date BMI calculated             / /</p>	<p>b. Dental</p> <p>1. Date of LAST Dental Exam             / /</p> <p>2. Do you have any broken, fragmented, loose, or non-intact natural teeth, including baby teeth that have fallen out?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently experiencing any tooth aches or pain?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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c. Weight Loss or Gain

1. Describe the foods or meals that you normally eat.

2. Has a 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 your 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

<p>1. Are you able to eat by mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are you able to feed yourself independently? <input type="checkbox"/> Yes <input type="checkbox"/> No          If no, explain.</p> <p>3. Dietary Modifications, if applicable  <input type="checkbox"/> i. Normal  <input type="checkbox"/> ii. Minced  <input type="checkbox"/> iii. Pureed solids  <input type="checkbox"/> iv. Thickened liquids</p>	<p>4. Do you require enteral feedings? <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> i. Nasogastric (NG) Tube  <input type="checkbox"/> ii. Gastrostomy Tube (GT)  <input type="checkbox"/> iii. Gastro/Jejunostomy (G/J) Tube</p> <p>5. Do you require parenteral feedings? <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> i. Total Parenteral Nutrition (TPN)  <input type="checkbox"/> ii. Other, parenteral feeding:</p>
--	---

f. Comments:

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<b>E8. Continence</b>		
a. Continence 1. Bladder Continence <input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Control with catheter or ostomy <input type="checkbox"/> 3. Incontinent	2. Bowel Continence <input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Control with ostomy <input type="checkbox"/> 3. Incontinent	b. Do you use any incontinence products? <input type="checkbox"/> Yes <input type="checkbox"/> No

c. Comments:

<b>E9. Skin</b>		
a. Skin 1. Do you have any history of skin breakdown or pressure sores? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Do you currently have any skin break down, tears, or open sores? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Do you have any blood, drainage, or odor from a wound? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Describe the wound(s) and location(s).		

b. Comments:

<b>E10. Musculoskeletal</b>		
a. Bones, Muscle, or Joints 1. Do you have any history of bone, muscle, or joint abnormalities or complications? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Do you currently have any bone, muscle, or joint abnormalities or complications? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Describe your bone, muscle, or joint abnormalities or complications. 4. Have you ever had a bone, muscle, or joint surgery or procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Date of Surgery/Procedure and Type. Date: / /                      Type:		

b. Comments:

<b>E11. Pregnant Female</b>	<b>(Complete this section if member is a pregnant female)</b>
-----------------------------	---

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

<b>a. Pregnant Female Only</b>		
1. Expected Date of Delivery    /    / 2. Date of Last Menstrual Period    /    / 3. Are you receiving prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Date of First Prenatal Visit    /    / 5. Date of Most Recent Prenatal Visit    /    / 6. Identify your prenatal care provider(s) <input type="checkbox"/> i. OB/GYN <input type="checkbox"/> ii. Midwife <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 11. If yes, explain. 12. Any current complications or is considered a high risk pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 17. Are there other supports after delivery? 18. If yes, explain.		

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19. Do you have plans for use of birth control after delivery?

b. Comments:

**SECTION F. 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, Heart Disease or have a BMI greater than 30, also complete F11. Shortness of Breath.

**F1. 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? Explain.  Yes  No
14. Explain your plan.

b. Comments:

**F2. Cancer**

a. Cancer

1. Are you currently being treated for cancer?  Yes  No
2. What type of cancer?
3. Describe your current status.

b. Comments:

**F3. 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?

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17. Do you have a blood pressure, heart, kidney or circulatory problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. If yes, explain.	
19. Have you had an eye exam in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Do you regularly check your feet for any open cuts, sores, swelling, tingling or discoloration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Are your feet regularly checked by a doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Do you have any amputations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. If yes, describe location(s).	

b. Comments:

**F4. 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Facility Name:	
ii. Location:	
iii. Telephone:	
3. What type of dialysis is currently being used?	
<input type="checkbox"/> i. Peritoneal	
<input type="checkbox"/> ii. Hemodialysis	
<input type="checkbox"/> iii. Other:	
4. If peritoneal, who is assisting with your dialysis?	
5. Dialysis frequency	
<input type="checkbox"/> i. Daily	
<input type="checkbox"/> ii. Three times per week	
<input type="checkbox"/> iii. Other:	
6. Current access type for dialysis	
<input type="checkbox"/> i. AV Fistula	
<input type="checkbox"/> ii. AV Graft	
<input type="checkbox"/> iii. Vas Cath	
7. Site most used	
<input type="checkbox"/> i. AV Fistula	
<input type="checkbox"/> ii. AV Graft	
<input type="checkbox"/> iii. Vas Cath	
8. Have you missed 1 or more dialysis appointments in the last 30 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. If yes, explain.	
10. How do you get to your dialysis appointment?	
11. Do you have help or supports after your dialysis treatments?	
12. Do you experience any problem(s) with your dialysis treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. If yes, explain.	

b. Comments:

**F5. Heart Disease**

a. Heart disease

1. Do you have a heart condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain.	
2. Have you had any heart surgeries?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)	
<input type="checkbox"/> i. Palpitations (feels like butterflies, pounding, skipping a beat, racing)	

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<input type="checkbox"/>	ii. Faster than normal heart rate (tachycardia)		
<input type="checkbox"/>	iii. Slower than normal heart rate (bradycardia)		
<input type="checkbox"/>	iv. Missing or skipping a heartbeat (irregular heart rhythm)		
<input type="checkbox"/>	v. Swelling below the knee or feet		
<input type="checkbox"/>	vi. Dizziness or feel like passing out (syncope)		
<input type="checkbox"/>	vii. Rapid Breathing		
<input type="checkbox"/>	viii. Pallor or Discoloration of hands, feet or lips		
<input type="checkbox"/>	ix. Excessive tiredness, decreased energy		
<input type="checkbox"/>	x. Drop in oxygen saturation		
	5. Do you get tired easily when walking shore distances or walking up or down stairs?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	8. Do you regularly check your blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	9. Do you regularly check your pulse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

b. Comments:

**F6. 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	3. Do you have any supports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	4. Do you need further support?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	5. If no, do you anticipate needing support in the future?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	6. Able to travel to scheduled doctor appointments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

b. Comments:

**F7. 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	3. How often is blood pressure being monitored?		
	4. Has your doctor set a goal for your blood pressure range?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	5. What is your doctor's recommended blood pressure range? _____ - _____		
	6. Is there a plan in place for managing blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	7. If yes, explain.		
	8. Do you have high blood sugar, kidney or circulatory problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	9. If yes, explain.		
	10. List your current symptoms that would indicate 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

b. Comments:

**F8. HIV/AIDS**

a. HIV/AIDS			
	1. Identify the current stage of your disease (HIV/AIDS).		
	<input type="checkbox"/> i. Acute Infection		
	<input type="checkbox"/> ii. Clinical latency (inactivity or dormancy)		
	<input type="checkbox"/> iii. AIDS		
	<input type="checkbox"/> iv. Unknown		
	2. Briefly describe your current symptoms related to your condition.		

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3. Experiencing any side effects from the medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have any help?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you need further help?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. If no, do you anticipate needing support in the future?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Able to travel to scheduled doctor appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No

b. Comments:

**F9. Seizures**

a. Seizures

1. Describe what happens when you have a 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, 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 is 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:

**F10. Shortness of Breath**

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:

**F11. Transplant**

a. Transplant

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

b. Comments:

**SECTION G. TRANSPORTATION**  
 \*\*\*Do not complete for NF\*\*\*

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

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- 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 H. HOME ENVIRONMENT**

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

a. Current Home

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

	Adequate	Inadequate	N/A	Comments
<b>b. Exterior Assessment</b>				
Walkways free of clutter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ramps/handrails safe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	#Exits <input type="checkbox"/> Accessible Locations

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Stair safe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	#steps/exit
Safe water source	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water catchment
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>c. Interior Assessment</b>				
Clear pathway to exit/entry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sturdy floors (other structural)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Handrails safe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stairs safe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	#steps/exit Locations
Free of trash accumulation/trash disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tacked down rugs and carpets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Visible cords/electrical circuits safe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Telephone service and accessibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Smoke/fire detector or fire extinguisher operational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Locations
Grab bars/support structures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Locations
Bathing/hand washing facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hot water <input type="checkbox"/> Running water
Food preparation areas clean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cooking appliances safe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Stove <input type="checkbox"/> Fridge <input type="checkbox"/> Freezer <input type="checkbox"/> Microwave
Food storage safe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pets in house (cats, dogs, etc.) secured.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Washer <input type="checkbox"/> Dryer
Insects/other pests or rodents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Smoke-free house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Guns/weapons (locked/unlocked)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sufficient space for equipment/supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Generator
Home ventilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Too hot <input type="checkbox"/> Too cold
Other:				
<b>d. Comments</b>				

**I. EMERGENCY PLANNING**

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

a. Emergency Contact(s)

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

b. Emergency Plan

1. Describe your Fire Evacuation Plan (Attach floor plan).
2. Describe your Disaster Evacuation Plan.
3. Where is the nearest Emergency Shelter:
4. Describe your Power Outage Back up Plan/Equipment.
5. Location of your fuse box/circuit breaker.
6. Location of your water turn off valve.
7. Is your Individualized Emergency Back-up Plan Form completed?     Yes     No



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c. Comments:		
<b>SECTION J. MEMBER NEEDS</b>		
<b>J1. Treatments and Therapy Needs</b>		
a. List Treatment and Therapy Needs		
Treatment/Therapy(ies)	Frequency	Comments
<b>J2. Medical Equipment and Supply Needs</b>		
a. List Medical Equipment and Supply Needs		
Medical Equipment/Supply(ies)	Type/Description	Comments
<b>J3. HCBS Needs</b>		
a. List HCBS Service(s) Needs		
HCBS Service(s)	Frequency	Comments
<b>J4. Institutional Needs</b>		
a. List Institutional Needs		
HCBS Service(s)	Comments	
<b>J5. Referrals</b>		
a. Referrals		
Service	Comments	
<b>SECTION K. EDUCATION</b>		
a. List Education		
Education that was Provided	Education Needs	Comments

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<b>SECTION L. SUMMARY/ADDITIONAL INFORMATION</b>	
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.	
<b>APPENDICES</b>	
<b>Appendix A. Treatments and Therapies</b>	
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
<b>Appendix B. Medical Equipment and Supplies</b>	
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
<b>Appendix C. HCBS Services</b>	
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 (C&T) 6. Community Care Foster Family Home (CCFFH) 7. Expanded Adult Residential Care Home (E-ARCH) 8. Environmental Accessibility Adaptations 9. Home Delivered Meals 10. Home Maintenance	11. Moving Assistance 12. Non-Medical Transportation 13. Personal Assistance Services – Level I (PA I) 14. Personal Assistance Services – Level II (PA II) 15. Personal Assistance- 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
<b>Appendix D. Institutional Services</b>	
1. Acute Waitlisted ICF/SNF 2. NF (SNF/ICF)	3. Sub-Acute Facility 4. Rehabilitation Center
<b>Appendix E. Diseases</b>	
1. Asthma	8. High Blood Pressure

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<ul style="list-style-type: none"> <li>2. Cancer</li> <li>3. Chronic Obstructive Pulmonary Disorder (COPD)</li> <li>4. Diabetes</li> <li>5. End Stage Renal Disease (ESRD)</li> <li>6. Heart Disease</li> <li>7. Hepatitis B/C</li> </ul>	<ul style="list-style-type: none"> <li>9. HIV/AIDS</li> <li>10. Seizures</li> <li>11. Shortness of Breath</li> <li>12. Transplant</li> <li>99. Other</li> </ul>
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**Appendix F. Acronyms**

<ul style="list-style-type: none"> <li>1. <b>ADC</b> Adult Day Care</li> <li>2. <b>ADH</b> Adult Day Health</li> <li>3. <b>ADLs</b> Activities of Daily Living</li> <li>4. <b>ALF</b> Assisted Living Facility</li> <li>5. <b>AMHD</b> Adult Mental Health Division</li> <li>6. <b>APS</b> Adult Protective Services</li> <li>7. <b>ARCH</b> Adult Residential Care Home</li> <li>8. <b>ASL</b> American Sign Language</li> <li>9. <b>BMI</b> Body Mass Index</li> <li>10. <b>CAMHD</b> Child and Adolescent Mental Health Division</li> <li>11. <b>CCFFH</b> Community Care Foster Family Home</li> <li>12. <b>CCMA</b> Community Care Management Agency</li> <li>13. <b>CWS</b> Child Welfare Services</li> <li>14. <b>DDD</b> Developmentally Disable Division</li> <li>15. <b>DHS</b> Department of Human Services</li> <li>16. <b>DOE</b> Department of Education</li> <li>17. <b>DOH</b> Department of Health</li> </ul>	<ul style="list-style-type: none"> <li>18. <b>EAA</b> Environmental Adaptations</li> <li>19. <b>E-ARCH</b> Expanded Adult Residential Care Home</li> <li>20. <b>EPSDT</b> Early and Periodic Screening, Diagnosis, and Treatment</li> <li>21. <b>HCBS</b> Home and Community Based Services</li> <li>22. <b>IADLs</b> Instrumental Activities of Daily Living</li> <li>23. <b>ICF</b> Intermediate Care Facility</li> <li>24. <b>LTSS</b> Long Term Services and Supports</li> <li>25. <b>MQD</b> Med-QUEST Division</li> <li>26. <b>NF</b> Nursing Facility</li> <li>27. <b>PA</b> Personal Assistant</li> <li>28. <b>PERS</b> Personal Emergency Response System</li> <li>29. <b>PCP</b> Primary Care Physician</li> <li>30. <b>SC</b> Service Coordinator</li> <li>31. <b>SHCN</b> Special Health Care Needs</li> <li>32. <b>SN</b> Skilled Nursing (Private Duty)</li> <li>33. <b>SNAP</b> Supplemental Nutrition Assistance Program</li> <li>34. <b>SNF</b> Skilled Nursing Facility</li> <li>35. <b>SP</b> Service Plan</li> </ul>
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