STATE OF HAWAII
Special Health Care Needs (SHCN)
CHILD SHCN ASSESSMENT INSTRUCTIONS
Up through 17 years old

SECTION A. ADMINISTRATIVE INFORMATION	
A1. Member	
a. Member Name	*a. Goal: To document personal information necessary to identify the member.* a. Instruction: Enter member's legal name (Last, First, Middle Initial). If member has no middle initial, leave blank.
b. Date of Birth	*b. Goal: To document personal information necessary to identify the member.* b. Instruction: Enter date of birth (MM/DD/YYYY). Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year.
c. Medicaid ID #	*c. Goal: To document personal information necessary to identify the member.* c. Instruction: Enter Medicaid Identification (ID) number assigned by the Department of Human Services (DHS).
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	*a. Goal: To document the reason for conducting an assessment.* a. Instruction: Check appropriate box to indicate reason for assessment. a. Definitions: 1. **Annual Assessment**- An assessment that is conducted annually. 2. **Discharge Assessment-** An assessment that is conducted prior to the date of discharge for institutionalized members who are preparing for discharge to the community. 3. **Initial Assessment-** First assessment completed. 4. **Reassessment due to a significant change in status-** A reassessment that is conducted within ten (10) days when significant events occur in the life of a member, including but not limited to, the death of a caregiver, significant change in health status, change in living arrangement, institutionalization and change in provider(s) (if the provider(s) change affects the service plan). 5. **Other-** An assessment conducted other than what is listed above. Enter other type of assessment e.g., follow up reassessment, etc.
b. Assessment Reference Information 1. Date 2. Time 3. Location 4. Identify any safety issues that a SC may encounter during the assessment.	*b. Goal: To document the assessment reference information which is the date, time, and location in which the assessment was conducted. Also to document any safety issues that a SC may encounter during the assessment.* b. Instruction: Enter the assessment reference information. 1. Enter date. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. 2. Enter time. Enter 2 digits for hour and minutes. Use zero (0) as a filler digit. Check "AM" or "PM." 3. Enter location e.g., members home, nursing facility, etc. 4. Safety issues include environmental hazards, dogs, etc.

c. Assessor(s) 1. Assessor Name 2. Title	*c. Goal: To document identifiers necessary to identify the assessor.* c. Instruction: Document assessor(s) information. The assessor is the person(s) that conducted the health and functional assessment. 1. Enter assessor's legal name 2. Enter assessor's title e.g., RN, SW, LSW etc.
d. Additional Health Plan 1. Health Plan Name 2. Subscriber Name 3. Subscriber Number	*d. Goal: To document any additional health plan insurance, if applicable. Review available supporting documentation. SC and provider(s) must be able to identify additional insurance to coordinate appropriate services without duplication.* d. Instruction: Identify any additional health plan insurance. 1. Enter health plan name. 2. Enter subscriber name, the person responsible for plan. 3. Enter subscriber number; most subscriber numbers can be located on the insurance card.
e. Individual(s) at the Assessment 1. Name of Individual 2. Relationship to Member	*f. Goal: To document other individual(s) that assisted during the assessment. SC and provider(s) must be able to identify the individual(s) that assisted during the assessment to assist with development and implementation of SP.* f. Instruction: Identify all other individual(s) that assisted during the assessment i.e., parent, legal guardian, spouse, sibling, aunt/uncle, interpreter, agency worker, etc. 1. Enter the assisting individual's legal name. 2. Enter the relationship to the member.
A3. Legal Information	
a. Legal Responsibility(ies) 1. Legal Guardian, Name 2. Authorized Representative, Name 3. Healthcare Power of Attorney, Name 4. Other 5. Identify parents or adults who are NOT allowed information on the member, only if identified on a legal document.	*a. Goal: To document the individual(s) that have legal responsibility(es) in regard to member. Review available supporting documentation. SC and provider(s) must be able to identify these individuals to coordinate services.* a. Instruction: Check all appropriate boxes that identify individuals that have legal responsibilities in regards to the member. 1. Enter legal guardian's legal name. 2. Enter authorized representative's legal name. 3. Enter healthcare power of attorney's legal name. 4. Enter legal responsibility and others legal name. 5. Document 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? 2. If yes, do you have a copy of the Advance Directive? 3. If no, would you like more information on Advance Directives? 4. Health Plan obtained copy for records 5. Do you have a Physician Orders for Life-Sustaining Treatment (POLST) 6. Location of POLST	*b. Goal: To document advance directives, if applicable. Review available supporting documentation. SC and provider(s) must be able to identify the member's needs as stated in the advance directives to coordinate services.* b. Instruction: 1. Check "Yes" or "No" to indicate whether the member has an Advance Directive. Skip to number 3 if checked "No." 2. Check "Yes" or "No" to indicate whether the member has a copy of the Advance Directive.

	3. Check "Yes" or "No" to indicate whether the member would like more information on Advance Directive. 4. Check "Yes" or "No" to indicate whether the health plan has obtained a copy the Advance Directive. 5. Check "Yes" or "No" to indicate whether the member has a Physician Orders for Life-Sustaining Treatment (POLST) 6. Document location of POLST.
c. Comments	c. Enter additional comments as needed.
A4. Emergency Contact(s)	
a. Emergency Contact(s) 1. Primary i. Name ii. Relationship to member iii. Address iv. Phone number v. Email address 2. Secondary i. Name ii. Relationship to member iii. Address iv. Phone number v. Email address	*a. Goal: To document member's emergency contacts. SC must be able to identify emergency contacts to participate in the development and implementation of emergency planning.* a. Instructions: Identify the primary and secondary emergency contacts. Enter name, relationship, address, contact number, and email address, if available.
b. Comments	b. Enter additional comments as needed.
A5. Long Term Services and Supports (LTSS)	
a. Long Term Services and Supports (LTSS) 1. Do you need companion services? 2. Do you needs assistance with chore services? 3. Do you need personal care assistance, i.e., bathing, toileting, etc.? 4. Do you need skilled nursing assistance, i.e., ventilator care, tracheostomy care, enteral feedings, etc.?	*a. Goal: To document any Long Term Services and Supports (LTSS) needs.* a. Instructions: Identify any LTSS needs. Check "Yes" or "No" to indicate whether the member needs LTSS services. If yes to any of these questions, SC will stop at this section of the assessment and must complete the LTSS Assessment. If no, continue this assessment.
SECTION B. DEMOGRAPHIC INFORMATION	
B1. Demographics	
a. Gender 1. Male 2. Female	*a. Goal: To document personal information necessary to identify the member.* a. Instruction: Document gender. Check "Male" or "Female" to indicate gender. If member is transgender, document preferred identified gender.
b. 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	*c. Goal: To document and understand member's ethnic background. Health plan staff and provider(s) must be culturally sensitive.* c. Instructions: Identify ethnicity. Check all appropriate boxes to indicate which best describe ethnicity. If "Other," enter ethnicity. Note: Federated State of Micronesia includes Yap, Chuuk, Pohnpei, and Kosrae.

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 vi. 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	*a. Goal: To document the members primary means of communication. Health plan staff and provider(s) must be able to communicate with the member.* a. Instruction: Check appropriate box to indicate primary means of communication. a. Definitions: 1. **Verbal-** Member is able to communicate verbally. 2. **Non Verbal-** Member is unable to communicate verbally but is able to communicate by using hand gestures, facial expressions, eye contact, body language etc. 3. **Written-** Member is unable to communicate verbally but prefers to and able to communicate in writing. 4. **American Sign Language-** Member is able to communicate through Sign Language primarily used in the United States. 5. **Other-** If "Other," enter type of communication e.g., speech communicating device etc.
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	*b. Goal: To document the member's primary spoken language. Health plan staff and provider(s) must be able to communicate with the member in a language other than English, if preferred.* b. Instructions: Check appropriate box to indicate preferred language for a day to day communication. If "Other," enter preferred language for a day to day communication.

c. Interpretation 1. Do you need an interpreter?	*c. Goal: To document interpretation services. Health plan staff and provider(s) must be able to communicate with the member and offer interpretation services, as needed.* c. Instructions: Check "Yes" or "No" to indicate whether the member needs interpreter services.
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	*d. Goal: To document the member's primary written language. Health plan staff and provider(s) must be able to communicate with the member in a written language other than English, if preferred.* d. Instructions: Check appropriate box to indicate preferred language for written materials. If "Other," enter preferred language for written materials.
e. Translation 1. Do you need for a translator?	*e. Goal: To document translation services. Health plan staff and provider(s) must be able to communicate with the member and offer translation services, as needed.* e. Instructions: Check "Yes" or "No" to indicate whether the member needs translation services.
f. Education 1. Education Level	*f. Goal: To document highest level of education.* f. Instructions: Enter member's highest level of education completed e.g., high school, college etc. If unknown, leave blank.
g. Other Assistive Communication Device(s) 1. Other Assistive Communication Device(s)	*g. Goal: To document use of any other assistive communication device(s).* g. Instructions: List all other assistive communication device(s) e.g., TTY, TTD, etc.
h. Comments	h. Enter additional comments as needed.
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	*a. Goal: To document where the member is currently residing. SC and provider(s) must be able to identify and verify current residence to coordinate services.* a. Instruction: Check appropriate box to indicate where the member is currently residing.

7. Acute care hospital 8. Other	a. Definitions: 1. **Own Private house/apartment-** Any house, apartment, or condominium owned by the member. 2. **Rent Private house/apartment/room-** Any house, apartment, condominium, or room rented by the member. 3. **Houseless (with or without shelter) -** Member has no permanent residence (a house, apartment, condominium, room, or a place to stay on a regular basis). Member may reside on the streets, in car, in open areas, or at a homeless shelter, e.g., Institute for Human Services (IHS), etc. 4. **Foster Home-** a home that a minor has been placed into as a ward of the State. 5. **Rehabilitation hospital/unit-** Any licensed acute care facility, e.g., Rehabilitation Hospital of the Pacific, etc. in the service area to which a member is admitted to rehabilitation services pursuant to arrangements made by a physician. 6. **Psychiatric hospital/unit-** Any licensed acute care facility, e.g., Kahi Mohala Behavioral Health, Kekela Queens Medical Center, etc. in the service area to which a member is admitted to receive psychiatric services pursuant to arrangements made by a physician. 7. **Hospital-** Any licensed acute care facility in the service area to which a member is admitted to receive inpatient services pursuant to arrangements made by a physician. 8. **Other-** If "Other," enter current residence, e.g., DD Domiciliary Homes, DD Foster Homes, ICF-ID, etc.
b. Living Arrangements 1. With parent(s)/guardian(s) 2. With sibling(s) 3. With other relative(s) 4. With non-relative(s) 5. Other	*b. Goal: To document current living arrangements. SC and provider(s) must be able to identify and verify current living arrangements to coordinate services.* b. Instructions: Check appropriate box to indicate the current living arrangement. If "Other," enter current living arrangements. b. Definitions: 1. **With parent(s)/guardian(s) -** Lives with parent(s) or guardian(s) only, or with parent(s) or guardian(s) and other individual(s) but not spouse or partner or child(ren). 2. **With sibling(s) -** Lives with sibling(s) only, or sibling(s) and other individual(s) but not spouse or partner, parent(s) or guardian(s) or child(ren). 3. **With other relative(s) -** Lives with relative(s) (i.e., aunt or uncle) only, or relative(s) and other individual(s) but not spouse or partner, parent(s) or guardian(s), sibling(s) or child(ren). 4. **With non-relative(s)-** Lives in a group setting (e.g., NF) 5. If "Other," enter living arrangements.
c. Comments	c. Enter additional comments as needed.
SECTION. C MEDICAL INFORMATION	
C1. Disease Diagnosis(es)	
a. Disease Diagnosis(es) 1. List Disease Diagnosis(es)	*a. Goal: To document current disease diagnosis(es) or medical conditions related to the members need for long term care services.*

2. ICD Code 3. Date of Onset	*SC and provider(s) must be able to understand disease process and identify needs based on member's current condition. Do not include conditions that have been resolved or no longer affect the member's ability to perform functional activities. Date of onset will assist in developing appropriate interventions and goals on the SP.* a. Instructions: Identify and list significant past and current disease diagnosis(es) or medical conditions related to the members need for long term care. 1. Enter significant disease diagnosis, medical condition, or surgical procedure. List the primary and secondary diagnosis(es) first. 2. Enter 3-5 digits for ICD code. Use zero (0) as a filler digit. 3. Enter date of onset. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank.
C2. Medications	
a. Medications 1. Do you take any medications, i.e., prescribed medications, vitamins, supplements, herbal or OTC medications? 2. List Current Medications i. Medication Name ii. Indication iii. Dose iv. Route v. Frequency vi. Prescribing Physician/Provider vii. Compliant viii. Comments	*a. Goal: To document member's current medications. SC and provider(s) must be able to identify medications and indications.* a. Instructions: List all current medications. 1. Check "Yes" or "No" if member is taking any medications, i.e., prescribed medications, vitamins, supplements, herbal or OTC medications. 2. List all current medications. i. Document Brand or Generic name ii. Document the purpose of the medication. iii. Document the recommended dose. Include measure, e.g., ml, mg, mcg, etc. iv. Document the route to administer medication, e.g., by mouth, IM, G Tube, etc. v. Document frequency medication is it given, e.g., BID, TID, Daily, PRN, etc. vi. Document prescribing physician/provider. If there is no ordering physician, for example taking Calcium as a supplement. Leave blank. vii. Check "Yes" or "No" if member is compliant taking medications. viii. Enter additional comments or special instructions as needed.
C3. Treatment(s) and Therapy(ies)	
a. List Treatment(s) and Therapy(ies) 1. Treatment/Therapy 2. Prescribing Physician/Provider 3. Provider/Agency 4. Frequency 5. Comments	*a. Goal: To document treatment(s) and therapy(ies) and assure necessary services are provided.* a. Instructions: Identify and list all treatment(s) and therapy(ies). 1. Document treatment/therapy name. Refer to Appendix A. Enter 2 digits for treatment/therapy. If "Other" enter 99 and document treatment/therapy. 2. Document ordering physician/provider. If there is no ordering physician, for example treatment discontinued but member would like to continue treatments as needed, leave blank.

	3. Document provider or agency delivering treatment/therapy, e.g. treatment is wound care and wound RN is from a home health agency. 4. Document frequency treatment/therapy is given, e.g., wound care BID, weekly, PRN, etc. 5. Enter additional comments or special instructions as needed.
C4. Medical Equipment and Supplies	
a. List Medical Equipment and Supplies 1. Medical Equipment and Supplies 2. Type/Description 3. Prescribing Physician/Provider 4. Indicate Rent or Own 5. Vendor and Phone Number 6. Comments	*a. Goal: To document medical equipment and supplies.* a. Instructions: Identify and list medical equipment and supplies. 1. Document medical equipment/supply. Refer to Appendix B. Enter 2 digits for medical equipment/supply. If "Other" enter 99 and document medical equipment/supply. 2. Brief description of medical equipment or supply, e.g., 4 X 4 split gauze, Devilbiss suction canister, etc. 3. Document ordering physician/provider. If there is no ordering physician or unknown, leave blank. 4. Select whether rent or own. 5. Document vendor or supplier and contact number. 6. Enter additional comments or special instructions as needed, e.g., supplies are delivered as needed or every 15th of the month, rental expires end of month.
C5. Physician(s) and Provider(s)	
a. Physician(s) and Provider(s) 1. List Physician(s)/Provider(s) Name 2. Specialty 3. Address 4. Phone Number 5. Fax Number	*a. Goal: To document current physician(s) and provider(s). SC must be able to identify current physician(s) and provider(s) to effectively communicate, collaborate, and coordinate services. The physician(s) and provider(s) will participate in the development and implementation of the SP.* a. Instructions: Identify and list current physician(s) and provider(s). 1. Enter the name of the physician or provider(s) name. List the primary physician/provider(s) first. 2. Enter physician/provider(s) specialty. 3. Enter physician/provider(s) address. 4. Enter physician/provider(s) phone number. 5. Enter physician/provider(s) fax number.
C6. Utilization of Hospital, Emergency Room, and Physician Services	
a. Hospital 1. Date of LAST Inpatient Acute Hospitalization 2. Reason	*a. Goal: To document date of last hospitalization. This information will assess the stability of the member's condition(s).* a. Instructions: Document last acute hospitalization. 1. Enter date of last inpatient acute hospitalization. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank. 2. Document response.
b. Emergency Room 1. Date of LAST Emergency Room visit (not counting overnight stay) 2. Reason	*b. Goal: To document date of last emergency room visit. This information will assess the stability of the member's condition(s).* b. Instructions: Document last emergency room visit. 1. Enter date of last emergency room visit (not counting overnight stay). Enter 2 digits for month and day. Use zero

	(0) as a filler digit. Enter 4 digits for year. If unknown, leave blank. 2. Document response.
c. Physician/Provider(s) 1. Date of LAST Physician (or Provider, Practitioner, Authorized Assistant) visit 2. Reason	*c. Goal: To document date of last physician (or provider, practitioner, authorized assistant) visit. This information will assess the stability of the member's condition(s).* c. Instructions: Document last physician (or provider, practitioner, authorized assistant) visit. 1. Enter date of last physician (or provider, practitioner, authorized assistant) visit. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank. 2. Document response.
d. Comments	b. Enter additional comments as needed.
C7. State Programs	
a. State Program(s) 1. Are you currently receiving services from any State Program(s)? 2. Identify the State Program(s) i. DOE/Special Education ii. DOE/Physical, Occupational or Speech Therapy iii. DOH/CAMHD iv. DOH/DDD v. DHS/CWS vi. Other: 3. State Program Contact Name and Phone Number 4. Number of service hours per week	*a. Goal: To document other State program(s) that the member is currently receiving services, if applicable. SC must be able to identify State program(s) to effectively communicate, collaborate, and coordinate services without duplication.* a. Instructions: Identify State Program(s). 1. Check "Yes" or "No" to indicate whether the member is currently receiving services from State program(s). If "Other," enter other state program(s). 2. If "Yes," check all appropriate boxes to indicate the State program(s). If "No," skip and continue assessment. If "Other," enter other State program. 3. Enter State program contact name and phone number. 4. Enter 2 digits for number of service hours receiving per week. Use zero (0) as a filler digit. If receiving 100 hours per week or greater, enter 3 digits. If unknown, leave blank.
b. Comments	b. Enter additional comments as needed.
C8. Prevention	
a. Preventive Screening(s) 1. LAST EPSDT screening 2. LAST Well Child visit 3. Pap Smear (for sexually active) in the LAST YEAR 4. Total Cholesterol measured in the LAST YEAR 5. Tuberculin (TB) Skin testing, PPD or 2 Step PPD in the LAST YEAR 6. TB Results Negative/Positive 7. TB Date of last Chest X-ray	*a. Goal: To document recommended child preventive screenings. Refer to the CDC Recommended Preventive Screenings for Child(ren) and QI Covered Preventive Services for Child(ren) (RFP Appendix J). Health plan and provider(s) must be able to identify whether the member has met recommended screenings to coordinate health education, counseling, and/or preventive care.* a. Instructions: Identify preventive screening(s) that was completed. 1. Identify date of last EPSDT screening. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank. 2. Identify date of last Well Child visit. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank. 3. Check "Yes" or "No" to indicate whether the preventive screening was completed. Check "N/A" if not applicable. Check "Unknown" if unknown.

	4. Check "Yes" or "No" to indicate whether the preventive screening was completed. Check "N/A" if not applicable. Check "Unknown" if unknown. 5. Check "Yes" or "No" to indicate whether the preventive screening was completed. Check "N/A" if not applicable. Check "Unknown" if unknown. 6. If "Yes" for TB Skin test, indicate "Negative" or "Positive." 7. If "Positive" for TB results, indicate date of Chest X-ray. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank.
b. Comments	b. Enter additional comments as needed.
C9. Immunizations	
a. Immunizations 1. Are your immunizations up to date? 2. Date of LAST Influenza Vaccination	*a. Goal: To document recommended Child immunizations. Refer to the Centers for Disease Control (CDC) Recommended Immunizations for Child(ren) and QUEST Integration (QI) Covered Preventive Services for Child(ren) (RFP Appendix J). Health plan and provider(s) must be able to identify whether the member has met recommended immunizations to coordinate health education, counseling, and/or preventive care.* a. Instructions: Identify that all immunizations are up to date. 1. Check "Yes," "No" or "Unknown" to indicate whether immunizations are up to date. Check "Unknown" if unknown. 2. Enter date of influenza vaccination. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank.
b. Comments	b. Enter additional comments as needed.
C10. 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? 2. If yes, explain	*a. Goal: To document personal beliefs and/or concerns that may affect the acceptance of healthcare assistance, treatments, or procedures. Health plan staff and provider(s) must be able to be culturally sensitive.* a. Instructions: Identify personal beliefs. 1. Check "Yes" or "No" to indicate whether the member has beliefs and/or concerns that may affect the acceptance for health care assistance, treatments, or procedures. 2. Document response.
b. Comments	b. Enter additional comments as needed.
SECTION D. PERSON CENTERED INFORMATION	
D1. Parents/Primary Caregiver	
a. Parents/Primary Caregiver Status 1. Describe feelings, are you ok? 2. Describe how you take care of yourself. 3. Do you need help caring for member? 4. At what point do you feel you will not be able to care for member and what happens then? 5. Do you have any other demands or responsibilities? 6. If yes, explain.	*a. Goal: To assess the member's parents/ primary caregiver status for possible caregiver burn out. SC and providers must be able to identify whether the parents/primary caregiver is experiencing caregiver burnout to coordinate caregiver supports e.g., respite care, education, and /or counseling etc.* a. Instruction: Assess the need for primary caregiver supports. 1. Document feelings e.g., feeling stressed, doing ok, tired, overwhelmed, etc.

	2. Document how parents/caregiver takes care of self if feeling overwhelmed with caregiving e.g., take walks, go out, have another caregiver help, etc. 3. Check "Yes" or "No" to indicate if parents/primary caregiver needs help providing care to member. 4. Document what will happen if s/he is unable to care for member e.g., another family member or friend will help or take over caregiving, member will go to a nursing facility or care home, etc. 5. Check "Yes" or "No" to indicate if parents/primary caregiver has any other demands or responsibilities. 6. Document any other demands or responsibilities e.g., being a caregiver for another family member, additional family responsibilities, etc.
b. Comments	b. Enter additional comments as needed.
SECTION E. GENERAL HEALTH	
E1. Birth History	
a. Birth History 1. Did your mother have any problems while she was pregnant with you? 2. If yes, describe. 3. Did you have any problems when you were born? 4. If yes, describe. 5. Did you have to stay in the Intensive Care Unit (ICU) after you were born? 6. If yes, describe.	*a. Goal: To document birth history which includes any problems during mother's pregnancy or immediately after birth.* a. Instructions: Identify any problems during mother's pregnancy or immediately after birth. 1. Check "Yes" or "No" to indicate whether member's mother had any problems while she was pregnant. 2. If, yes describe and document response. 3. Check "Yes" or "No" to indicate whether member had problems when s/he was born. 4. If, yes describe and document response. 5. Check "Yes" or "No" to indicate whether member was in the ICU after s/he was born. 6. If, yes describe and document response.
b. Comments	b. Enter additional comments as needed.
E2. Vision, Hearing, Speech, Expression, and Comprehension	
a. Vision 1. Visual impairment, Describe 2. Has/Uses corrective lenses or appliances i. Glasses ii. Contacts 3. Ability to see in adequate light with corrective lenses or appliances i. Adequate ii. Minimal difficulty iii. Moderate difficulty iv. Severe difficulty 4. Date of LAST Eye Exam	*a. Goal: To assess the member's ability to see objects in adequate light (with corrective lenses or appliances). SC and provider(s) must be able to identify visual impairments that may affect functional activities.* a. Instructions: Identify any visual impairments and assess the member's ability to see objects in adequate light (with or without corrective lenses or appliance). 1. Check "Yes" or "No" to indicate whether the member has a visual impairment. Document impairment e.g., near or far sightedness, legally blind, detached retina, color blind etc. 2. Check "Yes" or "No" to indicate whether the member has/uses corrective lenses or appliances. Then check "glasses" and/or "contacts" to indicate type of corrective lenses or appliance, if applicable. 3. Check appropriate box to indicate the member's ability to see in adequate light with corrective lenses or appliances.

	a. Test: With corrective lenses or appliances have member look at newspaper/book then have member read aloud the largest font to the smallest font. Observe eye movement and visual acuity. a. Definitions- i. **Adequate-** Able to see fine detail, including regular print. ii. **Minimal difficulty-** Able to see large print but not regular print. iii. **Moderate difficulty-** Has limited vision and unable to see print but is able to identify objects in environment. iv. **Severe difficulty-** Vision questionable but eyes track movement in the environment. May see shapes or colors. 4. Enter date of last eye exam. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank.
b. Hearing 1. Hearing impairment, Describe 2. Has/Uses hearing aids or appliances 3. Ability to hear with hearing aid or appliances i. Adequate ii. Minimal difficulty iii. Moderate difficulty iv. Severe difficulty 4. Date of LAST Hearing Exam	*b. Goal. To assess the members ability to hear (with hearing aids or appliances). SC and provider(s) must be able to identify hearing impairments that may affect functional activities or ability to communicate.* b. Instructions: Identify any hearing impairments and assess the member's ability to hear (with hearing aid or appliances). 1. Check "Yes" or "No" to indicate whether the member has a hearing impairment. Describes impairment e.g., hearing loss caused by genetics, environment, etc. 2. Check "Yes" or "No" to indicate whether the member has/uses hearing aids or appliances, if applicable. 3. Check appropriate box to indicate the member's ability to hear with functioning hearing aids or appliances. b. Test: With hearing aids or appliance continue with interview then ask about hearing function. Observe the members verbal responses and social interactions. b. Definitions- i. **Adequate-** Able to hear during social interaction and conversation. ii. **Minimal difficulty-** Some difficulty in some environments e.g., when someone is speaking softly or at a far distance. iii. **Moderate difficulty-** Difficulty hearing during social interaction and conversation. May hear in quieter environment. iv. **Severe difficulty-** Difficulty hearing in all environments e.g., assessor has to speak loudly or slowly, member does not respond to questions or speech is mumbled. 4. Enter date of last hearing exam. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank.
c. Speech 1. Speech pattern i. Coherent ii. Incoherent iii. No speech 2. Date of LAST Speech Evaluation	*c. Goal: To assess the member's speech clarity. SC and provider(s) must be able to identify speech impairments that may affect ability to communicate.* c. Instruction: Identify member's speech capability. 1. Check appropriate box to indicate the member's speech capability.

	c. Test: Interact with member, observe and listen for clarity in member's verbal responses. c. Definitions i. **Coherent-** Clear, comprehensible words ii. **Incoherent-** Unclear, slurred, mumbled iii. **No speech-** No spoken words 2. Enter date of last speech evaluation, if applicable. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank.
d. Expression 1. Ability to verbally express ideas i. Understood ii. Usually understood iii. Sometimes understood iv. Rarely or never understood	*d. Goal: To assess the members ability to express or communicate needs, requests, and engage in social conversation (i.e., in form of verbal, written, sign language or other communication device). SC and provider(s) must be able to identify any expression difficulty that may affect ability to communicate.* d. Instruction: Identify the member's ability to express ideas and ability to understand others. 1. Check appropriate box to indicate the member's ability express or communicate needs, requests, and engage in social conversation (i.e., in form of verbal, written, sign language or other communication device). d. Test: Interact with member, observe and listen to the members efforts to communicate with the assessor. d. Definitions- i. **Understood-** Able to express thoughts and ideas clearly without difficulty. ii. **Usually understood**- Able to express thoughts and ideas, may be delayed responses, has difficulty finding the right words, no prompting needed. iii. **Sometimes understood-** Able to express basic needs (i.e., eat, drink, sleep, toilet, etc.), difficulty finding words or finishing thoughts, prompting needed. iv. **Rarely or never understood-** Limited or unable to express thoughts and ideas
e. Comprehension 1. Ability to understand others i. Understands ii. Usually understands iii. Sometimes understands iv. Rarely or never understands	*e. Goal: To assess the members ability to express or communicate needs, requests, and engage in social conversation (i.e., in form of verbal, written, sign language or other communication device). SC and provider(s) must be able to identify any comprehension difficulty that may affect ability to communicate.* e. Instruction: Identify the member's ability to express ideas and ability to understand others. 1. Check appropriate box to indicate the member's ability to comprehend others (i.e., in form of verbal, written, sign language or other communication device). e. Test: Interact with member, observe and listen to the members responses. e. Definitions- i. **Understands-** Able to comprehend without difficulty. ii. **Usually understands**- Able to comprehend with minimal to no prompting, may miss some parts of conversation.

	iii. **Sometimes understands-** Has some difficulty comprehending, responds only to simple and direct questions. May need to rephrase question or use gestures to enhance comprehension. iv. **Rarely or never understands-** Limited or unable to comprehend based on verbal and non-verbal responses.
f. Comments	f. Enter additional comments as needed.
E3. Developmental Milestones	
a. Developmental Milestones 1. Infancy (Birth-12 months) i. Recognizes familiar people. ii. Follows objects with eyes both in same direction. iii. Pull to a standing position. iv. Know approx. five or six words 2. Toddler (1-3 years) i. Developing autonomy by becoming more independent and involved in self-care. ii. Spontaneously shows affection for familiar playmates, family and other familiar people. iii. Using or formulating sentence structure in their speech. iv. Able to walk up stairs and/or open a door. 3. Preschool (3-6 years) i. Developing mastery over movement and play. ii. Fantasizes and developing fears. iii. Developing ability to make choices. 4. School (6-12 years) i. Follows rules and likes to do things the "right way." ii. Enjoys school and peers. iii. Have supportive adults in their lives 5. Adolescence (12-18 years) i. Able to think abstractly/logical thought and deductive reasoning. ii. Concerns about looking and being different from others. iii. Ability to make choices and have control.	a. Goal: To assess any delays in developmental health. SC must be able to identify developmental changes to make a referral to PCP for further evaluation. a. Instructions: Identify any delays in developmental health. Check "Yes" or "No" to indicate whether member meets the developmental milestone. **Note: For members that do not meet the developmental milestones in the age group identified, SC will need to ask the questions that are relevant to member at the time of the assessment.**
b. Comments	b. Enter additional comments as needed.
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. Pediatric Symptom Checklist (PCS-17) How often does your child display the following: 1. Feels sad, unhappy i. Never ii. Sometimes	*a. Goal: To assess the member's needs for emotional and behavioral problems and/or risk for delay in emotional and behavioral development.*

iii. Often 2. Feels hopeless i. Never ii. Sometimes iii. Often 3. Dislikes themselves i. Never ii. Sometimes iii. Often 4. Worries a lot i. Never ii. Sometimes iii. Often 5. Seems to be having less fun i. Never ii. Sometimes iii. Often 6. Fidgety, unable to sit still i. Never ii. Sometimes iii. Often 7. Daydreams too much i. Never ii. Sometimes iii. Often 8. Distracted easily i. Never ii. Sometimes iii. Often 9. Has trouble concentrating i. Never ii. Sometimes iii. Often 10. Acts as if they have endless energy i. Never ii. Sometimes iii. Often 11. Fights with other children i. Never ii. Sometimes iii. Often 12. Does not listen to rules i. Never ii. Sometimes iii. Often 13. Does not care about others i. Never ii. Sometimes iii. Often 14. Teases others i. Never ii. Sometimes	*a.* Instructions: Assess for cognitive, emotional and behavioral problems, either self-reported or parent reported answers to questions 1-17. 1. Check the appropriate boxes questions 1-17 that are rated "Never", "Sometimes" or "Often". a. Definitions- i. **Never**- No problems. ii. **Sometimes**- 1 – 3 times a week. iii. **Often**- Occurring daily or more than 4 times a week.

iii. Often 15. Blames others for his/her troubles i. Never ii. Sometimes iii. Often 16. Does not like to share i. Never ii. Sometimes iii. Often 17. Takes things that do not belong to him/her i. Never ii. Sometimes iii. Often	
b. Score	b. Instructions: Add score for questions 1-17. Enter 2 digits for total score. Score may be 00-34. Use zero (0) as a filler digit. i. **Never**- Zero (0) points ii. **Sometimes**- 1 point iii. **Often**- 2 points b. Interpretation of Score: A total score of above 15 or higher suggests the presence of significant behavioral or emotional problems and the appropriate referrals should be made.
c. 1. Does your child have any emotional or behavioral problems for which she/he needs help? 2. If yes, please explain.	*c. Goal: To assess the member's needs for emotional and behavioral problems and/or risk for delay in emotional and behavioral development.* c. Instructions: Check "Yes" or "No" to indicate whether the member has emotional or behavioral problems that he/she needs help. (If no, no further action required. If yes, please document details and make comments for appropriate referral.)
d. 1. Has anything significant happened recently that impacts your child's life? 2. If yes, please identify.	*d. Goal: To assess the member's needs for emotional and behavioral problems and/or risk for delay in emotional and behavioral development.* d. Instructions: Check "Yes" or "No" to indicate whether the member has major life stressors. (If no, no further action required. If yes, please document details and make comments for appropriate referral.)
e. Comments	e. Enter additional comments as needed.
E5. Health Condition	
a. Allergies 1. Allergies 2. Specify	*a. Goal: To document all known allergies. SC and provider(s) must be able to identify allergies to develop safety precautions and interventions.* a. Instructions: Identify all known allergies. 1. Check "Yes" or "No" to indicate whether member has any known allergies. 2. Enter specific allergies.
b. Pain 1. Communication of Pain	*b. Goal: To evaluate current pain and pain management. SC and provider(s) must be able to identify effective and ineffective 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 3. Location 4. Type 5. Frequency 6. Intensity i. Numeric Rating Scale OR ii. FACES Pain Rating Scale 7. Break though pain 8. Pain management	*management to coordinate and provide appropriate services as needed.* b. Instructions: Evaluate current pain and pain management. 1. Check appropriate box to indicate individual reporting pain. 2. Check "Yes" or "No" to indicate whether member is currently experiencing pain. 3. Document location of pain. 4. Describe type of pain e.g., aching, stabbing, pressure, etc. Document response. 5. Describe frequency of pain e.g., constant, intermittent, etc. Document response. 6. Document intensity of pain. Assessor may use the FACES Pain Rating Scale or Numeric Rating Scale (0-10). 7. Check "Yes" or "No" to indicate whether member has experienced break through pain. 8. Describe all methods of pain management e.g., change position, pain medication, relaxation, etc.
c. Substance Use 1. Tobacco i. Do you use any tobacco products? ii. How often and how many? iii. Does the amount you smoke present any problem(s) for you? iv. If yes, are you interested or willing to quit? 2. Alcohol i. Do you drink any alcohol products? ii. How often and how many? iii. Does the amount you drink present any problem(s) for you? iv. If yes, are you interested or willing to quit? 3. Other Substance i. Do you use any other substance(s)? ii. What substance(s)? iii. How often and how much? iv. Does the amount present any problem(s) for you? v. If yes, are you interested or willing to quit? 4. Have you received treatment for tobacco, alcohol, and/or substance abuse?	*c. Goal: To evaluate substance use and willingness to change. SC and provider(s) must be able to identify substance use to coordinate and provide appropriate services as needed.* c. Instructions: Evaluate tobacco, alcohol, and other substance use. 1. Tobacco i. Check "Yes" or "No" to indicate whether member uses tobacco products e.g., cigarettes, electronic or vaporized cigarettes, etc. If no, skip to question 2 Alcohol. ii. Document how often member smokes and how many, e.g., smokes daily, 2 packs a day iii. Check "Yes" or "No" if member feels that the amount presents any problems. iv. If yes, check "Yes" or "No" to indicate whether member is interested or willing to quit. 2. Alcohol i. Check "Yes" or "No" to indicate whether member uses alcohol products e.g., beer, wine, alcoholic energy drinks, etc. If no, skip to question 3 Other Substance. ii. Document how often member drinks and how many, e.g., drinks every day, 4-5 drinks throughout the day or 2-3 per sitting. iii. Check "Yes" or "No" if member feels that the amount presents any problems. iv. If yes, check "Yes" or "No" to indicate whether member is interested or willing to quit. 3. Other Substance i. Check "Yes" or "No" to indicate whether member uses other substances. If no, skip next two questions. ii. Identify substance, document response. iii. Document how often and how much.

	iv. Check "Yes" or "No" if member feels that the amount presents any problems. v. If yes, check "Yes" or "No" to indicate whether member is interested or willing to quit. 4. Check "Yes" or "No" to indicate whether member is currently or has received treatment for tobacco, alcohol, and/or other substance use.
d. Comments	d. Enter additional comments as needed.
E6. 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:	*a. Goal: To document the member's current height, weight, and Body Mass Index (BMI) to monitor nutrition and stability. SC and provider(s) must be able to identify changes in weight or nutrition to coordinate health education, counseling, and/or disease management.* a. Instructions: Record most recent height, weight, and BMI calculation. SC may obtain information from the most recent provider visit. 1. Enter 1-2 digits for feet and 1-2 digits for inches. Use zero (0) as a filler digit. If unknown, leave blank. i. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank. 2. Enter 1-3 digits for pounds. Use zero (0) as a filler digit. If unknown, leave blank. i. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank. 3. Enter 3 digits for BMI Calculation. If unknown, leave blank. Refer to the National Institutes of Health (NIH) Body Mass Index Table 1 at *www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm* i. Enter 3 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank.
b. Dental 1. Date of LAST Dental Exam 2. Do you have any broken, fragmented, loose, non-intact natural teeth, including baby teeth that have fallen out? 3. Are you currently experiencing any tooth aches or pain?	*b. Goal: To document any current dental problems or concerns. SC and provider(s) must be able to identify dental barriers to oral intake.* b. Instructions: Identify any dental problems or concerns. 1. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank. 2. Check "Yes" or "No" to indicate whether member has any broken, fragmented, loose, non-intact natural teeth, baby teeth that have fallen out. 3. Check "Yes" or "No" to indicate whether member has/uses dentures. 4. Check "Yes" or "No" to indicate whether member has complaints of tooth aches or pain.
c. Weight Loss or Gain 1. Describe the foods or meals that you normally eat.	*c. Goal: To document weight loss or weight gain. SC and provider(s) must be able to identify changes in nutrition to coordinate health education, counseling, and/or disease management.*

2. Has a physician or provider recommended a special diet for you? 3. If yes, explain. 4. Has a physician or provider counseled you for your weight? 5. If yes, physician or provider counseled you for weight loss or weight gain? 6. Is there a plan for managing your weight? 7. If yes, describe your plan.	c. Instructions: Identify weight loss or weight gain. 1. Document response. 2. Check "Yes" or "No" to indicate whether member is on a special diet. 3. If yes, document special diet response. 4. Check "Yes" or "No" to indicate whether member is currently or has received a physician consult or counseling for your weight. 5. If yes, check "Weight gain" or "Weight loss." 6. Check "Yes" or "No" to indicate whether member has weight management (e.g., calorie count, exercise, meal planning or nutrition log, etc.). 7. If yes, document response.
d. Swallowing 1. Have you ever experienced dry mouth? 2. Do you have difficulty chewing and/or swallowing? 3. If yes, did you have a swallow evaluation? 4. Date of swallow evaluation 5. Do you hold food in your mouth/cheek instead of swallowing? 6. Do you cough or choke during meals or when swallowing medications?	*d. Goal: To evaluate member's ability to swallow and risk for malnutrition or aspiration. SC and provider(s) must be able to identify difficulty swallowing and malnutrition to coordinate and provide appropriate services as needed.* d. Instructions: Identify swallowing problems or concerns. 1. Check "Yes" or "No" to indicate whether member has experienced dry mouth. 2. Check "Yes" or "No" to indicate whether member has difficulty chewing and/or swallowing. 3. Check "Yes" or "No" to indicate whether member has had a swallow evaluation. 4. Enter date of swallow evaluation. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank. Enter type of surgical procedure performed. 5. Check "Yes" or "No" to indicate whether member holds food in mouth or cheek. 6. Check "Yes" or "No" to indicate whether member has coughing or choking during meals or when swallowing medications.
e. Mode of Nutritional Intake 1. Are you able to eat by mouth? 2. Are you able to feed yourself independently? 3. If no, explain. 4. Dietary Modifications i. Normal ii. Minced iii. Pureed solids iv. Thickened liquids	*e. Goal: To evaluate mode of nutritional intake. SC and provider(s) must be able to identify dietary modifications if applicable to coordinate and provide appropriate services as needed.* *e.* Instructions: Identify mode of nutritional intake and dietary modifications. If member requires tube or parenteral feedings, refer to Skilled Nursing Tool to determine allotted hours. 1. Check "Yes" or "No" to indicate whether member is eating by mouth. 2. Check "Yes" or "No" to indicate whether member is able to feed self independently. 3. If no, explain and document response. 4. Check appropriate dietary modification, if applicable.
f. Comments	f. Enter additional comments as needed.
E7. Musculoskeletal	
a. Bones, Muscles, or Joints 1. Do you have any history of bone, muscle, or joint abnormalities or complications?	*a. Goal: To document current musculoskeletal condition. SC and provider(s) must be able to identify any bone, muscle, or joint*

2. Do you currently have any bone, muscle, or joint abnormalities or complications? 3. Describe your bone, muscle, or joint abnormalities or complications. 4. Have you ever had a bone, muscle, or joint surgery or procedure? 5. Date of Surgery/Procedure and Type	*problems that affect functional activities to coordinate and provide appropriate services as needed.* b. Instructions: Identify any musculoskeletal problems. 1. Check "Yes" or "No" if member has any history of bone, muscle, or joint abnormalities or complications. 2. Check "Yes" or "No" if member has any current bone, muscle, or joint abnormalities or complications. If yes, continue to question 3. If no, skip this section. 3. Describe current bone, muscle, or joint abnormalities or complications. Document response. 4. Check "Yes" or "No" if member has or had any surgical procedures performed for bone, muscle, or joint. 5. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. If unknown, leave blank. Enter type of surgical procedure performed.
b. Comments:	b. Enter additional comments as needed.
E8. 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? 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? 11. If yes, explain. 12. Any current complications or is considered a high risk pregnancy? 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? 17. Are there other help after delivery? 18. If yes, explain. 19. Do you have plans for use of birth control after delivery?	*a. Goal: To document whether mother and child are receiving prenatal care. SC and provider(s) must be able to coordinate appropriate services to promote a healthy pregnancy.* a. Instructions: Document pregnancy information for pregnant female only. 1. Enter estimated date for delivery. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. 2. Enter estimated date of last menstrual period. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. 3. Check "Yes" or "No" if member is receiving prenatal care. 4. Enter date of first prenatal visit. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. 5. Enter date of most recent prenatal visit. Enter 2 digits for month and day. Use zero (0) as a filler digit. Enter 4 digits for year. 6. Select all prenatal care providers. If not being seen by a physician or provider, SC to make appropriate referral. 7. Identify how member gets to appointments, e.g., takes public transportation, family member drives her in car. 8. Document total number of pregnancies. 9. Document total number of births. 10. Check "Yes" or "No" if member has a history of complications. 11. If yes, document history complication. 12. Check "Yes" or "No" if member has current complications or is considered a high risk pregnancy. 13. If yes, document current complications or reason for being considered a high risk pregnancy. 14. Document response to plans for delivery, e.g., delivering baby at a certain hospital, working till delivery, etc. 15. Document response to plans after delivery, e.g., plans to return to work right away, will stay home most of time, etc.

	16. Check "Yes" or "No" if member plans on breast feeding. If yes, document whether member will purchase a breast pump or needs assistance. SC to make referral, as needed. 17. Check "Yes" or "No" if member has other help after delivery. 18. If yes, document other help after delivery, e.g., family member will help watch baby, no help, etc. 19. Check "Yes," "No" or "Unknown" if member has plans for use of birth control after delivery. Document response to use of any birth control, e.g., plan on using oral contraceptives, does not believe in the use of birth control, etc.
b. Comments:	b. Enter additional comments as needed.

SECTION F. DISEASE SPECIFIC QUESTIONS

Goal: To identify status of current disease process. SC and provider(s) must be able to understand the disease to assist in developing appropriate interventions and goals on the SP.

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 E11. 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?
4. How often do you use a peak flow meter?
5. Do you have a rescue inhaler?
6. How often do you use your rescue inhaler?
7. Do you use a nebulizer?
8. How often do you use your nebulizer?
9. Do you know what triggers your respiratory condition?
10. List your respiratory triggers.
11. Are you having difficulty sleeping at night due to respiratory symptoms?
12. Do you have difficulty performing activities of daily living (ADLs) due to respiratory symptoms?
13. If yes, do you receive help from family or is there a plan in place for managing your respiratory condition?
14. Explain your plan.

b. Comments:	b. Enter additional comments as needed.

F2. Cancer

a. Cancer

1. Are you currently being treated for cancer?
2. What type of cancer
3. Describe your current status.

b. Comments:	b. Enter additional comments as needed.

F3. Diabetes

a. Diabetes

1. Briefly describe your current symptoms related to your diabetes.
2. Do you currently monitor your blood sugar levels?
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?
7. What is your doctor's recommended blood sugar range? ____-____
8. Is there a plan in place for managing blood sugar levels?
9. If yes, explain.
10. Are you on insulin?

11. If yes, how do you administer your insulin, e.g., injections, pump.
12. Do you sense when your blood sugar levels are low?
13. If yes, what are your symptoms?
14. Do you sense when your blood sugar levels are high?
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?
18. If yes, explain.
19. Have you had an eye exam in the last 12 months?
20. Do you regularly check your feet for any open cuts, sores, swelling, tingling or discoloration?
21. Are your feet regularly checked by a doctor?
22. Do you have any amputations?
23. If yes, describe location(s).

b. Comments:	b. Enter additional comments as needed.

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:
    a. Facility Name
    b. Location
    c. Telephone
3. What type of dialysis is currently being used?
    a. Peritoneal
    b. Hemodialysis
    c. Other:
4. If peritoneal, who is assisting with your dialysis?
5. Dialysis frequency
    a. Daily
    b. Three times per week
    c. Other:
6. Current access type for dialysis
    a. AV Fistula
    b. AV Graft
    c. Vas Cath
7. Site most used
    a. AV Fistula
    b. AV Graft
    c. Vas Cath
8. Have you missed 1 or more dialysis appointments in the last 30 days?
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?
13. If yes, explain.

b. Comments:	b. Enter additional comments as needed.

F5. Heart Disease

a. Heart disease

1. Do you have a heart condition? If yes, explain.
2. Have you had any heart surgeries?
3. If yes, what are the type(s) and dates of your heart procedure(s), e.g., valve surgery, catheterization.
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. Rapid Breathing
viii. Pallor or Discoloration of hands, feet or lips
ix. Excessive tiredness, decreased energy
x. Drop in oxygen saturation

5. Do you get tired easily when walking short distances or walking up or down stairs?
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?
8. Do you regularly check your blood pressure?
9. Do you regularly check your pulse?

b. Comments:	b. Enter additional comments as needed.

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?
3. Do you have any help?
4. Do you need further help?
5. If no, do you anticipate needing help in the future?
6. Able to travel to scheduled doctor appointments?

b. Comments:	b. Enter additional comments as needed.

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?
3. How often is blood pressure being monitored?
4. Has your doctor set a goal for your blood pressure range?
5. What is your doctor's recommended blood pressure range? ____-____
6. Is there a plan in place for managing blood pressure?
7. If yes, explain.
8. Do you have high blood sugar, kidney or circulatory problems?
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?

b. Comments:	b. Enter additional comments as needed.

F8. 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?
4. Do you have any help?
5. Do you need further help?
6. If no, do you anticipate needing help in the future?

7. Able to travel to scheduled doctor appointments?	
b. Comments:	b. Enter additional comments as needed.
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? 5. Are there things that can cause your seizures such as fever, bright lights, and certain illnesses? 6. If yes, describe. 7. Do you usually know when a seizure is going to happen? 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? 12. If yes, describe. 13. Have you been told by your doctor when to call 911? 14. If yes, describe. 15. Have others living with you been trained in CPR?	
b. Comments:	b. Enter additional comments as needed.
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? 5. If yes, explain.	
b. Comments:	b. Enter additional comments as needed.
F11. Transplant	
a. Transplant 1. Have you had a transplant? 2. Type of transplant 3. Describe current status.	
b. Comments:	b. Enter additional comments as needed.
SECTION G. TRANSPORTATION	
a. Assessor Determination 1. Is the member alert and aware of surroundings? 2. Is the member able to understand and respond to verbal commands?	*a. Goal: To assess member's cognition for safe transportation services.* a. Instructions: Identify cognition to ensure safety for member during transportation.
b. Transportation 1. Current Mode of Transportation (Select all that apply) i. Family vehicle ii. Friends vehicle iii. Public transportation a. Bus b. Handi Van iv. Van a. Curb to curb b. Door to door c. Gurney	*b. Goal. To document current mode of transportation and to assess need for transportation services.* b. Instructions: Identify current mode of transportation and transportation need. Once transportation and attendant needs are identified no additional questions need to be asked. 1. Select all that apply for current mode of transportation. If "Other," enter mode of transportation. If member selects i. drives own vehicle or ii. Family or friends, skip this section. 2. Check "Yes" or "No" if member is able to use public transportation or someone can regularly transport. 3. If no, explain and document response.

v. Taxi vi. Air travel for specialist care vii. Other: 2. Able to use public transportation or someone regularly transports you to medical services? 3. If no, explain. 4. Able to ambulate without assistance (with or without device, to include wheelchair)? 5. Able to ambulate to the local bus stop (both house and medical appointments)? 6. If no, explain. 7. If wheelchair bound are you able to self-propel to curb side for pick up? 8. If wheelchair bound, are you able to transfer in and out of vehicle without assistance? 9. Identify attendant for medical appointments. 10. Requires a nurse for medical appointments. 11. Does the member require any medical equipment when traveling? 12. If yes, list medical equipment (e.g., oxygen, 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	4. Check "Yes" or "No" if member is able to ambulate without assistance (with or without assistive device). 5. Check "Yes" or "No" if member able to ambulate to the local bus stop. Identify whether member can ambulate from house to the local bus stop, from the bus stop to medical appointment. 6. If no, explain and document response. If yes, SC should consider bus pass for transportation. 7. Wheelchair bound only: Check "Yes" or "No" if member is able to self-propel to curbside for pick up. 8. Wheelchair bound only: Check "Yes" or "No" if member is able to transfer in and out of vehicle without assistance. 9. Document attendant for medical appointments. 10. Check "Yes" or "No" if a nurse is required. 11. Check "Yes" or "No" if member requires any medical equipment when traveling? 12. If yes, list medical equipment (e.g., ventilator, suction machine, feeding pump, etc.). Enter 2 digits for medical equipment. Refer to Appendix B. 13. Select all that apply for the reason member is unable to get to curb side. SC to consider authorization for handi van, van, or taxi for medical appointment transportation.
c. Comments	c. Enter additional comments as needed.
SECTION H. MEMBER NEEDS	
SC will use this section to identify member needs.	
H1. Treatment and Therapy Needs	
a. List Treatment and Therapy Needs 1. Treatment/Therapy(ies) 2. Frequency 3. Comments	*a. Goal: To document treatment(s) and therapy(ies) needed or recommended.* a. Instructions: List treatment and therapy needs. 1. Document recommended treatment/therapy name. Refer to Appendix A. Enter 2 digits for treatment/therapy. If "Other" enter 99 and document treatment/therapy. 2. Document recommended frequency. 3. Enter additional comments as needed.
H2. Medical Equipment and Supply Needs	
a. List Medical Equipment and Supply Needs 1. Medical Equipment/Supply(ies) 2. Type/Description 3. Comments	*a. Goal: To document medical equipment and supply needed or recommended.* a. Instructions: List medical equipment and supply needs. 1. Document recommended medical equipment or supply. Refer to Appendix B. Enter 2 digits for medical equipment/supply. If "Other" enter 99 and document medical equipment/supply.

	2. Brief description of recommended medical equipment or supply, e.g., 4 X 4 split gauze, Devilbiss suction canister, etc. 3. Enter additional comments as needed.
H3. Referrals	
a. Referrals 1. Service 2. Comments	*a. Goal: To identify needs to coordinate appropriate referrals.* a. Instructions: List referral needs. 1. Service 2. Enter additional comments as needed.
SECTION I. EDUCATION	
a. List Education 1. Education that was provided 2. Education Needs 3. Comments	*a. Goal: To identify any education needs.* a. Instructions: List education that was provided during assessment and education needs. 1. Document education that was provided. Refer to Appendix A-E. Enter Appendix Letter and 2 digits for type of education, e.g., educated member on Catheter care Appendix A-02. If "Other" enter 99 and document education. 2. Document education needs. Refer to Appendix A-E. Enter Appendix Letter and 2 digits for type of education. If "Other" enter 99 and document education. 3. Enter additional comments as needed.
SECTION J. SUMMARY/ADDITIONAL INFORMATION	
a. Goal: To document a brief summary of visit. 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 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	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

12. Hospital Bed 13. Incontinence supplies 14. Nebulizer 15. Ostomy 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 (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
Appendix D. Institutional Services	
1. Acute Waitlisted ICF/SNF 2. NF (SNF/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 12. **CCMA** Community Care Management Agency 13. **CWS** Child Welfare Services 14. **DDD** Developmentally Disabilities Division 15. **DHS** Department of Human Services 16. **DOE** Department of Education 17. **DOH** Department of Health	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 29. **PCP** Primary Care Physician 30. **SC** Service Coordinator 31. **SHCN** Special Health Care Needs 32. **SN** Skilled Nursing (Private Duty) 33. **SNAP** Supplemental Nutrition Assistance Program 34. **SNF** Skilled Nursing Facility 35. **SP** Service Plan

STATE OF HAWAII
Special Health Care Needs (SHCN)
CHILD SHCN ASSESSMENT INSTRUCTIONS
Up through 17 years old