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

## SECTION A. ADMINISTRATIVE INFORMATION

### A1. Member

a. Member Name

Last First MI

b. Date of Birth
/ /

c. Medicaid ID#

### A2. Assessment

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

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

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

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

e. 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)
- ☐ 1. Legal Guardian
  Name:
- ☐ 2. Authorized Representative
  Name:
- ☐ 3. Healthcare Power of Attorney
  Name:
- ☐ 4. Other
  Name:
- ☐ 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?
   ☐ Yes ☐ No
2. If yes, do you have a copy of the Advance Directive?
   ☐ Yes ☐ No
3. If no, would you like more information on Advance Directives?
   ☐ Yes ☐ No
4. Health Plan obtained copy for records
   ☐ Yes ☐ No
5. Do you have a Physician Orders for Life-Sustaining Treatment (POLST) ☐ Yes ☐ No
6. Location of POLST:

c. Comments:

### A4. Emergency Contact(s)

a. Emergency Contact(s)

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

b. Comments:

### A5. Long Term Services and Supports (LTSS)

a. Long Term Services and Supports (LTSS)

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

## SECTION B. DEMOGRAPHIC INFORMATION

### B1. Demographics

a. Gender

- ☐ 1. Male
- ☐ 2. Female

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
  - ☐ ix. Other
- ☐ 4. Caucasian
- ☐ 5. Hispanic or Latino
- ☐ 6. Native Hawaiian or other Pacific Islander
  - ☐ i. Federated State of Micronesia
  - ☐ ii. Native Hawaiian
  - ☐ iii. Palauan
  - ☐ iv. Marshallese
  - ☐ v. Samoan
  - ☐ vii. Tongan
  - ☐ vii. Other
- ☐ 7. Other:

### B2. Communication

a. Primary Means of Communication

- ☐ 1. Verbal
- ☐ 2. Non Verbal
- ☐ 3. Written
- ☐ 4. American Sign Language
- ☐ 5. Other:

b. Primary Spoken Language

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

c. Interpretation

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

d. Primary Written Language

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

e. Translation

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

f. Education

1. Education Level:

g. Other Assistive Communication Device(s)

1. Other Assistive Communication Device(s):

h. Comments:

### B3. Residence and Living Arrangements

a. Residence

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

b. Living Arrangements

- ☐ 1. With parent(s)/guardian(s)
- ☐ 2. With sibling(s)
- ☐ 3. With other relative(s)
- ☐ 4. With non-relative(s)
- ☐ 5. Other:

c. Comments:

## SECTION. C MEDICAL INFORMATION

### C1. Disease Diagnosis(es)

a. Disease Diagnosis(es)

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

### C2. Medications

a. Medications

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

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

### C3. Treatment(s) and Therapy(ies)

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

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

### C4. Medical Equipment and Supplies

a. List Medical Equipment and Supplies

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

| | | | ☐ Rent ☐ Own | | |
|---|---|---|---|---|---|
| | | | ☐ Rent ☐ Own | | |

**C5. Physician(s) and Provider(s)**

a. Physician(s) and Provider(s)

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

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

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

d. Comments:

**C7. State Programs**

a. State Program(s)

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

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

b. Comments:

**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 ☐ Yes ☐ No ☐ Unknown ☐ N/A
4. Total Cholesterol measured in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
5. Tuberculin (TB) Skin testing, PPD or 2 Step PPD in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
6. TB Results Negative/Positive ☐ Negative ☐ Positive
7. TB Date of last Chest X-ray / /

b. Comments:

**C9. Immunizations**

a. Immunizations

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

b. Comments:

**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? ☐ Yes ☐ No
2. If yes, explain.

b. Comments:

**SECTION D. PERSON CENTERED INFORMATION**

**D1. Parents/Primary Caregiver**

a. Parents/Primary Caregiver Status

1. Describe your feelings, are you ok?
2. Describe how you take care of yourself.
3. Do you need help caring for member? ☐ Yes ☐ No
4. At what point do you feel you will not be able to care for member and what happens then?
5. Do you have other demands or responsibilities? ☐ Yes ☐ No
6. 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**

a. Vision

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

b. Hearing

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

c. Speech

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

d. Expression

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

e. Comprehension

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

f. Comments:

**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

b. Comments:

**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
How often has your child been affected by any of the following problems:

| | Never (0) | Sometimes (1) | Often (2) |
|---|---|---|---|
| 1. Feels sad, unhappy | ☐ | ☐ | ☐ |
| 2. Feels hopeless | ☐ | ☐ | ☐ |
| 3. Dislikes themselves | ☐ | ☐ | ☐ |
| 4. Worries a lot | ☐ | ☐ | ☐ |
| 5. Seems to be having less fun | ☐ | ☐ | ☐ |
| 6. Fidgety, unable to sit still | ☐ | ☐ | ☐ |
| 7. Daydreams too much | ☐ | ☐ | ☐ |
| 8. Distracted easily | ☐ | ☐ | ☐ |
| 9. Has trouble concentrating | ☐ | ☐ | ☐ |
| 10. Acts as if they have endless energy | ☐ | ☐ | ☐ |
| 11. Fights with other children | ☐ | ☐ | ☐ |
| 12. Does not listen to rules | ☐ | ☐ | ☐ |
| 13. Does not care about others | ☐ | ☐ | ☐ |
| 14. Teases others | ☐ | ☐ | ☐ |

| | | | |
|---|---|---|---|
| 15. Blames others for his/her troubles | ☐ | ☐ | ☐ |
| 16. Does not like to share | ☐ | ☐ | ☐ |
| 17. Takes things that do not belong to him/her | ☐ | ☐ | ☐ |

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 happened recently that impacts your child's life? ☐ Yes ☐ No
2. If yes, please identify.

e. Comments:

**E5. Health Condition**

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

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

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

d. Comments:

**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 Calculation _____
   i. Date BMI calculated:
   / /

b. Dental
1. Date of LAST Dental Exam
   / /
2. Do you have any broken, fragmented, loose, or non-intact natural teeth, including baby teeth that have fallen out?
   ☐ Yes ☐ No
3. Are you currently experiencing any tooth aches or pain?
   ☐ Yes ☐ No

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
1. Are you able to eat by mouth? ☐ Yes ☐ No
2. Are you able to feed yourself independently? ☐ Yes ☐ No
3. If no, explain.
4. Dietary Modifications, if applicable
   ☐ i. Normal
   ☐ ii. Minced
   ☐ iii. Pureed solids
   ☐ iv. Thickened liquids

f. Comments:

**E7. Musculoskeletal**

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

b. Comments:

**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? ☐ Yes ☐ No
4. Date of First Prenatal Visit / /
5. Date of Most Recent Prenatal Visit / /
6. Identify your prenatal care provider(s)
   - ☐ i. OB/GYN
   - ☐ ii. Midwife
   - ☐ iii. Other
7. How do you get to your scheduled appointments?
8. Total number of pregnancies:
9. Total number of births:
10. Any history of pregnancy/delivery complications? ☐ Yes ☐ No
11. If yes, explain.
12. Any current complications or is considered a high risk pregnancy? ☐ Yes ☐ No
13. If yes, explain.
14. What are your plans for delivery?
15. What are your plans after delivery?
16. Are you planning on breast feeding? ☐ Yes ☐ No
17. Are there other help after delivery?
18. If yes, explain.
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 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? ☐ 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 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?
17. Do you have a blood pressure, heart, kidney or circulatory problems? ☐ Yes ☐ No
18. If yes, explain.
19. Have you had an eye exam in the last 12 months? ☐ Yes ☐ No
20. Do you regularly check your feet for any open cuts, sores, swelling, tingling or discoloration? ☐ Yes ☐ No
21. Are your feet regularly checked by a doctor? ☐ Yes ☐ No
22. Do you have any amputations? ☐ Yes ☐ No
23. If yes, describe location(s).

b. Comments:

**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:
   i. Facility Name:
   ii. Location:
   iii. Telephone:
3. What type of dialysis is currently being used?
   ☐ i. Peritoneal
   ☐ ii. Hemodialysis
   ☐ iii. Other:
4. If peritoneal, who is assisting with your dialysis?
5. Dialysis frequency
   ☐ i. Daily
   ☐ ii. Three times per week
   ☐ iii. Other:
6. Current access type for dialysis
   ☐ i. AV Fistula
   ☐ ii. AV Graft
   ☐ iii. Vas Cath
7. Site most used
   ☐ i. AV Fistula

- ☐ ii. AV Graft
- ☐ iii. Vas Cath

8. Have you missed 1 or more dialysis appointments in the last 30 days? ☐ Yes ☐ No
9. If yes, explain.
10. How do you get to your dialysis appointment?
11. Do you have help after your dialysis treatments?
12. Do you experience any problem(s) with your dialysis treatments? ☐ Yes ☐ No
13. If yes, explain.

b. Comments:

**F5. Heart Disease**

a. Heart disease

1. Do you have a heart condition? ☐ Yes ☐ No
   If yes, explain.
2. Have you had any heart surgeries? ☐ Yes ☐ No
3. If yes, what are the type(s) and dates of your heart procedure(s), e.g., valve surgery, catheterization.
   Heart Procedure: Date: / /
   Heart Procedure: Date: / /
4. Have you experienced any of the following (Select all that apply)
   - ☐ i. Palpitations (feels like butterflies, pounding, skipping a beat, racing)
   - ☐ ii. Faster than normal heart rate (tachycardia)
   - ☐ iii. Slower than normal heart rate (bradycardia)
   - ☐ iv. Missing or skipping a heartbeat (irregular heart rhythm)
   - ☐ v. Swelling below the knee or feet
   - ☐ vi. Dizziness or feel like passing out (syncope)
   - ☐ vii. 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 shore distances or walking up or down stairs? ☐ Yes ☐ No
6. How do you know that your heart condition is getting worse (i.e., weight gain, shortness of breath, swelling of lower extremities, facial droop, aphasia, angina, lightheadedness etc.)
7. Do you regularly check your weight? ☐ Yes ☐ No
8. Do you regularly check your blood pressure? ☐ Yes ☐ No
9. Do you regularly check your pulse? ☐ Yes ☐ No

b. Comments:

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

3. How often is blood pressure being monitored?
4. Has your doctor set a goal for your blood pressure range? ☐ Yes ☐ No
5. What is your doctor's recommended blood pressure range? _____-_____
6. Is there a plan in place for managing blood pressure? ☐ Yes ☐ No
7. If yes, explain.
8. Do you have high blood sugar, kidney or circulatory problems? ☐ Yes ☐ No
9. If yes, explain.
10. List 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? ☐ Yes ☐ No

b. Comments:

**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? ☐ Yes ☐ No
4. Do you have any help? ☐ Yes ☐ No
5. Do you need further help? ☐ Yes ☐ No
6. If no, do you anticipate needing help in the future? ☐ Yes ☐ No
7. Able to travel to scheduled doctor appointments? ☐ Yes ☐ 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. Type of transplant.
3. Describe current status.

b. Comments:

## SECTION G. TRANSPORTATION

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

b. Transportation
1. Current Mode of Transportation (Select all that apply)
   - ☐ i. 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
   - ☐ 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. Identify attendant for medical appointments.
10. Requires a nurse for medical appointments. ☐ Yes ☐ No
11. Does the member require any medical equipment when traveling? ☐ Yes ☐ No
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

c. Comments:

## SECTION H. MEMBER NEEDS

SC will use this section to identify member needs.

**H1. Treatments and Therapy Needs**

a. List Treatment and Therapy Needs

| Treatment/Therapy(ies) | Frequency | Comments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**H2. Medical Equipment and Supply Needs**

a. List Medical Equipment and Supply Needs

| Medical Equipment/Supply(ies) | Type/Description | Comments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**H3. Referrals**

a. Referrals

| Service | Comments |
|---|---|
| | |
| | |
| | |
| | |

## SECTION I. EDUCATION

a. List Education

| Education that was Provided | Education Needs | Comments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## SECTION J. SUMMARY/ADDITIONAL INFORMATION

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

## APPENDICES

**Appendix A. Treatments and Therapies**

1. BiPAP/CPAP
2. Catheter care
3. Chemotherapy
4. Chest physiotherapy
5. Cough Insufflator/Exsufflator
6. Dialysis
7. Enteral Feeding
8. Home Health
9. Hospice care
10. IV therapy
11. Occupational therapy
12. Oxygen therapy
13. Palliative care
14. Personal Emergency Response System (PERS)
15. Physical therapy
16. Psychological therapy
17. Radiation
18. Respiratory therapy
19. Speech language therapy
20. Suctioning
21. Tracheostomy care
22. Transfusion
23. Ventilator care
24. Wound care
99. Other

**Appendix B. Medical Equipment and Supplies**

1. Bath chair/shower bench
16. Oxygen concentrator

2. BiPAP/CPAP
3. Cane
4. Catheter Supplies
5. Chest Vest
6. Commode
7. Cough Insufflator/Exsufflator
8. Enteral Feeding Supplies
9. Feeding Pump
10. Grab bars
11. Hand held shower head
12. Hospital Bed
13. Incontinence supplies
14. Nebulizer
15. Ostomy Supplies
17. Oxygen tank
18. Patient lift
19. Personal Emergency Response System (PERS)
20. Pulse oximeter
21. Scooter
22. Specialty mattress
23. Stander
24. Suction machine
25. Toilet Chair
26. Tracheostomy Supplies
27. Transfer board
28. Walker
29. Wheelchair
99. Other

**Appendix C. HCBS Services**

1. Adult Day Care (ADC)
2. Adult Day Health (ADH)
3. Assisted Living Facility (ALF)
4. Community Care Management Agency (CCMA) Services
5. Counseling and Training (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
18. **EAA** Environmental 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

14. **DDD** Developmentally Disable Division
15. **DHS** Department of Human Services
16. **DOE** Department of Education
17. **DOH** Department of Health

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