

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

SECTION A. ADMINISTRATIVE INFORMATION

A1. Member

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

a. Reason for Assessment <input type="checkbox"/> 1. Annual Assessment <input type="checkbox"/> 2. Discharge Assessment <input type="checkbox"/> 3. Initial Assessment <input type="checkbox"/> 4. Reassessment due to a significant change in status <input type="checkbox"/> 5. Other:	b. Assessment Reference Information <input type="checkbox"/> 1. Date / / <input type="checkbox"/> 2. Time __:__ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> 3. Location: <input type="checkbox"/> 4. Identify any safety issues that a SC may encounter during the assessment.
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c. Assessor 1. Assessor Name: 2. Title:	d. Additional Health Plan 1. Health Plan Name: 2. Subscriber Name: 3. Subscriber Number:
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e. Medicare 1. Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Medicare Advantage <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Medicare ID #	f. Other Individual(s) at the Assessment 1. Is there a legal guardian, or representative assisting in the assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Name of Individual: Relationship to Member: 3. Name of Individual: Relationship to Member: 4. Name of Individual: Relationship to Member: 5. Name of Individual: Relationship to Member:
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A3. Legal Information

a. Legal Responsibility(ies) <input type="checkbox"/> 1. Self <input type="checkbox"/> 2. Legal Guardian Name: <input type="checkbox"/> 3. Authorized Representative Name: <input type="checkbox"/> 4. Healthcare Power of Attorney Name: <input type="checkbox"/> 5. Other Name:	b. Advance Directives 1. Do you have an Advance Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. If yes, do you have a copy of the Advance Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. If no, would you like more information on Advance Directives? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Health Plan obtained copy for records <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Do you have a Physician Orders for Life-Sustaining Treatment (POLST) <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Location of POLST:
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c. Comments:

SECTION B. DEMOGRAPHIC INFORMATION

B1. Demographics

a. Gender <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female	b. Relationship Status <input type="checkbox"/> 1. Single <input type="checkbox"/> 4. Separated <input type="checkbox"/> 2. Married <input type="checkbox"/> 5. Widowed <input type="checkbox"/> 3. Divorced <input type="checkbox"/> 6. Other:
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STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

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, e.g., prescribed medications, vitamins, supplements, herbal or OTC medications?

Yes No

2. List Current Medications

Medication Name	Indication	Dose	Route	Frequency	Prescribing Physician/Provider	Compliant	Comments
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	

C3. Treatments and Therap(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
			<input type="checkbox"/> Rent <input type="checkbox"/> Own		
			<input type="checkbox"/> Rent <input type="checkbox"/> Own		
			<input type="checkbox"/> Rent <input type="checkbox"/> Own		
			<input type="checkbox"/> Rent <input type="checkbox"/> Own		
			<input type="checkbox"/> Rent <input type="checkbox"/> Own		

C5. HCBS Services

a. List HCBS Services

HCBS Service	Provider/Agency	Frequency	Comments

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

C6. Institutional Services				
a. List Institutional Services				
Institutional Service	Provider	Comments		
C7. Physician(s) and Provider(s)				
a. Physician(s) and Provider(s)				
List Physician(s)/Provider(s) Name	Specialty	Address	Phone Number	Fax Number
C8. Utilization of Hospital, Emergency Room, and Physician Services				
Services	Date	Reason		
a. LAST Inpatient Acute Hospitalization	/ /			
b. LAST Emergency Room visit (not counting overnight stay)	/ /			
c. LAST Physician (or Provider, Practitioner, Authorized Assistant) visit	/ /			
d. Comments:				
C9. State Programs				
Do not complete for NF/CCFH/E-ARCH				
a. Other State Program(s)				
1. Are you currently receiving services from other State Program(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
2. Identify State Program(s)				
	State Program	Contact Name	Phone Number	Number of Service Hours per week
<input type="checkbox"/>	DOE/Special Education			
<input type="checkbox"/>	DOE/Physical, Occupational or Speech Therapy			
<input type="checkbox"/>	DOH/CAMHD			
<input type="checkbox"/>	DOH/AMHD			
<input type="checkbox"/>	DOH/DDD			
<input type="checkbox"/>	DHS/CWS			
<input type="checkbox"/>	DHS/APS			
<input type="checkbox"/>	Other:			
b. Comments:				
C10. Prevention				
a. Preventative Screening(s)				
1. Blood Pressure measured in the LAST YEAR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
2. Breast Cancer screening in the LAST YEAR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
3. Cervical Cancer screening in the LAST YEAR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
4. Colorectal screening in the LAST YEAR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
5. Osteoporosis in the LAST YEAR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
6. Prostate Cancer screening in the LAST 2 YEARS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

7. Total Cholesterol measured in the LAST YEAR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
8. Tuberculin (TB) Skin testing, PPD or 2 Step PPD in the LAST YEAR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
9. TB Results Negative/Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive		
10. Date of last TB Chest X-ray	/ /			
11. Weight/Height measured in the LAST YEAR	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
12. Well member visit/EPSTD screening (18 to 20 years) in the LAST YEAR	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

b. Comments:

C11. Immunizations

a. Immunizations

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

b. Comments:

C12. Personal Beliefs

<p>a. Personal Beliefs</p> <ol style="list-style-type: none"> 1. Do you have any beliefs and/or concerns that may affect your acceptance of health care assistance, treatments, or procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. If yes, explain: 	<p>b. Comments:</p>
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SECTION D. PERSON CENTERED INFORMATION

D1. Personal Interview

a. Personal Interview

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

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

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

b. Comments:

D2. Finances

*****Do not complete for NF/CCFH/E-ARCH*****

<p>a. Finances</p> <ol style="list-style-type: none"> 1. Are you able to pay for your major monthly expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. If no, explain. 3. Are you receiving financial assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Are you receiving SNAP? <input type="checkbox"/> Yes <input type="checkbox"/> No 	<p>b. Comments:</p>
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D3. Social Supports

*****Do not complete for NF/CCFH/E-ARCH*****

a. Social Supports

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

STATE OF HAWAII
Long Term Services and Support (LTSS)
ADULT LTSS ASSESSMENT TOOL
18 years and older

Name	Age	Relationship	Cell Phone	Day/Hours NOT available	Type of help	# of hours helped in LAST 7 days	Paid <input type="checkbox"/> Yes <input type="checkbox"/> No	Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer	Work hours/ week
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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

Name	Age	Relationship	Cell Phone	Day/Hours available	Type of help	# of hours helped in LAST 7 days	Paid <input type="checkbox"/> Yes <input type="checkbox"/> No	Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer	Work hours/ week
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

3. Strong and supportive relationship with family? Yes No

b. Comments:

D4. Primary Caregiver

*****Do not complete for NF/CCFH/E-ARCH*****

a. Primary Caregiver Status

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

b. Comments:

SECTION E. GENERAL HEALTH

E1. Vision, Hearing, Speech, Expression, and Comprehension

a. Vision

1. Visual impairment Yes No
Describe:
2. Has/Uses 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 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

d. Expression

1. Ability to verbally express ideas

e. Comprehension

1. Ability to understand others

STATE OF HAWAII
Long Term Services and Support (LTSS)
ADULT LTSS ASSESSMENT TOOL
18 years and older

<input type="checkbox"/> i. Coherent <input type="checkbox"/> ii. Incoherent <input type="checkbox"/> iii. No speech 2. Date of LAST speech evaluation / /	<input type="checkbox"/> i. Understood <input type="checkbox"/> ii. Usually understood <input type="checkbox"/> iii. Sometimes understood <input type="checkbox"/> iv. Rarely or never understood	<input type="checkbox"/> i. Understands <input type="checkbox"/> ii. Usually understands <input type="checkbox"/> iii. Sometimes understands <input type="checkbox"/> iv. Rarely or never understands
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f. Comments:

E2. Cognition

a. Repetition 1. Ability to repeat _____ (object), _____ (animal), and _____ (number) <input type="checkbox"/> i. None <input type="checkbox"/> ii. One Correct <input type="checkbox"/> iii. Two Correct <input type="checkbox"/> iv. Three Correct	b. Orientation 1. Able to report correct year <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect 2. Able to report correct month <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect 3. Able to report correct day of week <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect 4. Able to report current president of the United States <input type="checkbox"/> Correct <input type="checkbox"/> Incorrect	c. Recall 1. Ability to recall _____ (object), _____ (animal), and _____ (number) <input type="checkbox"/> i. None <input type="checkbox"/> ii. One Correct <input type="checkbox"/> iii. Two Correct <input type="checkbox"/> iv. Three Correct
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d. Score:	e. Comments:
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E3. Mood, Behavior, and Psychological Well Being

Note: Disease management may be appropriate for member that has been previously diagnosed. If member does not have a behavioral health diagnosis, SC should refer member to PCP for further evaluation.

a. Depression (PHQ-9 Foundation)
Over the LAST 2 WEEKS , how often have you been bothered by any of the following problems:

	None	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b. Score

c. Coping Skills
1. Do you have difficulty at work, caring for things at home, or getting along with people? Yes No

d. Anger
 1. Do you get angry easily? Yes No
 2. Have you ever felt persistent anger with yourself or others? Yes No
 3. If yes, describe what happens when you get angry.

e. Anxiety
 1. Do you get anxious easily or worry excessively? Yes No
 2. Do you suffer from panic attacks? Yes No

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

3. Do you ever feel like something terrible is going to happen? <input type="checkbox"/> Yes <input type="checkbox"/> No				
f. Behavior				
1. Have you been wandering? <input type="checkbox"/> Yes <input type="checkbox"/> No				
2. Have you been verbally abusive to yourself and/or others? <input type="checkbox"/> Yes <input type="checkbox"/> No				
3. Have you been physically abusive to yourself and/or others? <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. Have you been socially inappropriate or displayed disruptive behaviors? <input type="checkbox"/> Yes <input type="checkbox"/> No				
5. Have you been resisting caregiving? <input type="checkbox"/> Yes <input type="checkbox"/> No				
g. Social Relationships				
1. Have you ever had conflict or anger with family or friends? <input type="checkbox"/> Yes <input type="checkbox"/> No				
2. If yes, explain.				
3. Have you ever felt fearful of a family member or close acquaintance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. If yes, explain.				
5. Have you ever felt neglected, abused, or mistreated? <input type="checkbox"/> Yes <input type="checkbox"/> No				
6. If yes, explain.				
h. Major Life Stressor(s)				
1. Have you had any recent major life stressor(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
2. If yes, explain.				
i. Comments:				
E4. Functional Status				
a. Instrumental Activities of Daily Living (IADLs)				
	Independent	Minimal	Moderate	Total
1. Routine house cleaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Shopping and Errands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Activities of Daily Living (ADLs)				
	Independent	Minimal	Moderate	Total
1. Eating/Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Dressing upper body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Dressing lower body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Grooming/Personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Walks with or without assistive device Identify assistive device(s):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Ambulation/Locomotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have difficulty accessing areas of your house? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain.			
10. Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Medication assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Activity and Mobility				
1. Do you exercise or engage in moderate physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> No				
2. How many days per week do you exercise?				
3. How many total hours per week?				
4. Are there any physical limitations and/or environmental barriers that make it difficult for you to exercise or perform activities? <input type="checkbox"/> Yes <input type="checkbox"/> No				
5. If yes, explain.				
6. Do you feel that you are capable of increasing physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> No				
7. If yes or no, explain.				
d. Comments:				

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

E5. Health Condition	
<p>a. Vitals</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>1. Temperature: ____ F i. Mode:</p> <p>2. Pulse: ____ bpm i. Mode:</p> <p>3. Respirations: ____ per min</p> <p>4. Oxygen Saturation: ____% i. Mode:</p> </div> <div style="width: 45%;"> <p>5. Blood Pressure: ____/____ i. Location: ii. Position: iii. Usual blood pressure range: - / -</p> </div> </div>	

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

3. BMI: <u> </u> / <u> </u> / <u> </u> i. Date BMI calculated: <u> </u> / <u> </u> / <u> </u>	3. Are you currently experiencing any tooth aches or pain? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Date of LAST Dental Exam: <u> </u> / <u> </u> / <u> </u>
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c. Weight Loss or Gain

1. Describe the foods or meals that you normally eat.
2. Has a physician or provider recommended a special diet for you? Yes No
3. If yes, explain.
4. Has a physician or provider counseled you for your weight? Yes No
5. If yes, physician or provider counseled you for weight loss or weight gain? Loss Gain
6. Is there a plan for managing your weight? Yes No
7. If yes, describe 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

<ol style="list-style-type: none"> 1. Are you able to eat by mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Dietary Modifications <ul style="list-style-type: none"> <input type="checkbox"/> i. Normal <input type="checkbox"/> ii. Minced <input type="checkbox"/> iii. Pureed solids <input type="checkbox"/> iv. Thickened liquid 	<ol style="list-style-type: none"> 3. Do you require enteral feedings? <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> <input type="checkbox"/> i. Nasogastric (NG) Tube <input type="checkbox"/> ii. Gastrostomy Tube (GT) <input type="checkbox"/> iii. Gastrojejunostomy (G/J) Tube 4. Do you require parenteral feedings? <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> <input type="checkbox"/> i. Total Parenteral Nutrition (TPN) <input type="checkbox"/> ii. Other, parenteral feeding:
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f. Comments:

E7. Continence

<p>a. Continence</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <ol style="list-style-type: none"> 1. Bladder Continence <ul style="list-style-type: none"> <input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Control with catheter or ostomy <input type="checkbox"/> 3. Incontinent </td> <td style="width: 50%; border: none; vertical-align: top;"> <ol style="list-style-type: none"> 2. Bowel Continence <ul style="list-style-type: none"> <input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Control with ostomy <input type="checkbox"/> 3. Incontinent </td> </tr> </table>	<ol style="list-style-type: none"> 1. Bladder Continence <ul style="list-style-type: none"> <input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Control with catheter or ostomy <input type="checkbox"/> 3. Incontinent 	<ol style="list-style-type: none"> 2. Bowel Continence <ul style="list-style-type: none"> <input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Control with ostomy <input type="checkbox"/> 3. Incontinent 	<p>b. Do you use incontinence products? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<ol style="list-style-type: none"> 1. Bladder Continence <ul style="list-style-type: none"> <input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Control with catheter or ostomy <input type="checkbox"/> 3. Incontinent 	<ol style="list-style-type: none"> 2. Bowel Continence <ul style="list-style-type: none"> <input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Control with ostomy <input type="checkbox"/> 3. Incontinent 		

c. Comments:

E8. Skin

a. Skin

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

b. Comments:

E9. Musculoskeletal

a. Bones, Muscles, or Joints

1. Do you have any history of bone, muscle, or joint abnormalities or complications? Yes No
2. Do you currently have any bone, muscle, or joint abnormalities or complications? Yes No
3. Describe your bone, muscle, or joint abnormalities or complications.

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

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:

E10. Pregnant Female (Complete this section if member is a pregnant female)

Do not complete for NF/CCFH/E-ARCH

a. Pregnant Female Only

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

b. Comments:

SECTION 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.

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? Yes No
5. Do you have a rescue inhaler? Yes No
6. How often do you use your rescue inhaler? Yes No
7. Do you use a nebulizer? Yes No
8. How often do you use your nebulizer? Yes No
9. Do you know what triggers your respiratory condition? Yes No
10. List your respiratory triggers.
11. Are you having difficulty sleeping at night due to respiratory symptoms? Yes No
12. Do you have difficulty performing activities of daily living (ADLs) due to respiratory symptoms? Yes No
13. If yes, do you receive help from family or is there a plan in place for managing your respiratory condition? Yes No

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

14. Explain your plan.
b. Comments:
F2. Cancer
a. Cancer
1. Are you currently being treated for cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Type of Cancer. 3. Describe your current status.
b. Comments:
F3. Chronic Obstructive Pulmonary Disorder (COPD)
a. COPD
1. Briefly describe your current respiratory symptoms. 2. Are your symptoms getting better or worse in the last 12 months? 3. Do you use a peak flow meter? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. How often do you use a peak flow meter? 5. Do you have a rescue inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. How often do you use your rescue inhaler? 7. Do you use a nebulizer? <input type="checkbox"/> Yes <input type="checkbox"/> No 8. How often do you use your nebulizer? 9. Do you know what triggers your respiratory condition? <input type="checkbox"/> Yes <input type="checkbox"/> No 10. List your respiratory triggers. 11. Are you having difficulty sleeping at night due to respiratory symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No 12. Do you have difficulty performing activities of daily living (ADLs) due to respiratory symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No 13. If yes, do you receive help from family or is there a plan in place for managing your respiratory condition? <input type="checkbox"/> Yes <input type="checkbox"/> No 14. Explain your plan. 15. Do you use supplemental oxygen? <input type="checkbox"/> Yes <input type="checkbox"/> No 16. Oxygen Flow rate _____ LPM 17. Mode of oxygen delivery.
b. Comments:
F4. Diabetes
a. Diabetes
1. Briefly describe your current symptoms related to your diabetes. 2. Do you currently monitor your blood sugar levels? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. What is your doctor's recommended blood sugar range? _____ - _____ 8. Is there a plan in place for managing blood sugar levels? <input type="checkbox"/> Yes <input type="checkbox"/> No 9. If yes, explain. 10. Are you on insulin? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 13. If yes, what are your symptoms? 14. Do you sense when your blood sugar levels are high? <input type="checkbox"/> Yes <input type="checkbox"/> No 15. If yes, what are your symptoms? 16. How do you manage your low blood sugar levels? 17. Do you have blood pressure, heart, kidney or circulatory problems? <input type="checkbox"/> Yes <input type="checkbox"/> No

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

<input type="checkbox"/>	iv. Missing or skipping a heartbeat (irregular heart rhythm)		
<input type="checkbox"/>	v. Swelling below the knee or feet		
<input type="checkbox"/>	vi. Dizziness or feel like passing out (syncope)		
<input type="checkbox"/>	vii. Chest pain relieved with rest		
<input type="checkbox"/>	viii. Stroke		
5.	Do you get tired easily when walking short distances or walking up or down stairs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	How do you know that your heart condition is getting worse (i.e., weight gain, shortness of breath, swelling of lower extremities, facial droop, aphasia, angina, lightheadedness, etc.)		
7.	Do you regularly check your weight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Do you regularly check your blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Do you regularly check your pulse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

b. Comments:

F7. Hepatitis B/C

a. Hepatitis B/C			
1.	Briefly describe your current symptoms related to your condition.		
2.	Are you experiencing any side effects from the medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Do you have any help?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Do you need more help?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	If no, do you anticipate needing help in the future?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Are you able to travel to scheduled doctor appointments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

b. Comments:

F8. High Blood Pressure

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

b. Comments:

F9. HIV/AIDS

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

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

b. Comments:

F10. Seizures

a. Seizures

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

b. Comments:

F11. 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:

F12. Transplant

a. Transplant

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

b. Comments:

SECTION G. TRANSPORTATION

*****Do not complete for NF/CCFH/E-ARCH*****

a. Assessor Determination

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

b. Transportation

1. Current Mode of Transportation (Select all that apply)
 - i. Drives own vehicle
 - ii. Family or friends
 - iii. Public transportation
 - a. Bus
 - b. Handi van

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

- iv. Van
 - a. Curb to curb
 - b. Door to door
 - c. Gurney
 - v. Taxi
 - vi. Air Travel for specialist care
 - vii. Other:
2. Are you able to use public transportation or can someone regularly transport you to obtain medical services? Yes No
3. If no, explain.
4. Are you able to ambulate without assistance (with or without device, includes wheelchair)? Yes No
5. Are you able to ambulate to the local bus stop? Yes No
6. Describe.
7. If wheelchair bound, are you able to self-propel to curb side for pick up? Yes No
8. If wheelchair bound, are you able to transfer in and out of vehicle without assistance? Yes No
9. If the member needs assistance, do you have an attendant? Yes No
10. Do you require any medical equipment when traveling? Yes No
11. If yes, list medical equipment (e.g., ventilator, suction machine, feeding pump, etc.)
12. Are you able to get to curb side alone (If No, select all that apply) Yes No
- i. No attendant
 - ii. Attendant is unable to help member to curb side
 - iii. Member is bedbound
 - iv. Member is non ambulatory
 - v. Member is unable to transfer or receive assistance

c. Comments:

SECTION H. HOME ENVIRONMENT

*****Do not complete for NF/CCFH/E-ARCH*****

a. Current Home

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

	Adequate	Inadequate	N/A	Comments
b. Exterior Assessment				
Walkways free of clutter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ramps/handrails safe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	#Exits <input type="checkbox"/> Accessible Locations
Stairs safe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	#steps Locations
Safe water source	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water catchment
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

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

SECTION I. EMERGENCY PLANNING

Do not complete for NF/CCFH/E-ARCH

a. Emergency Contact(s)

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

b. Emergency Plan

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

c. Comments:

SECTION J. MEMBER NEEDS

J1. Treatments and Therapy Needs

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

a. List Treatment and Therapy Needs		
Treatment/Therapy	Frequency	Comments

J2. Medical Equipment and Supply Needs

a. List Medical Equipment and Supply Needs		
Medical Equipment/Supply	Type/Description	Comments

J3. HCBS Needs

a. List HCBS Service Needs		
HCBS Service	Frequency	Comments

J4. Institutional Needs

a. List Institutional Needs	
Institutional Service	Comments

J5. Referrals

a. Referrals	
Service	Comments

SECTION K. EDUCATION

a. List Education		
Education that was Provided	Education Needs	Comments

SECTION L. 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.

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

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 12. Hospital Bed 13. Incontinence supplies 14. Nebulizer* 15. Ostomy Supplies	16. Oxygen concentrator* 17. Oxygen tank* 18. Patient lift 19. Personal Emergency Response System (PERS) 20. Pulse oximeter* 21. Scooter 22. Specialty mattress 23. Stander 24. Suction machine* 25. Toilet Chair 26. Tracheostomy Supplies* 27. Transfer board 28. Walker 29. Wheelchair 99. Other
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) 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 (EAA) 9. Home Delivered Meals 10. Home Maintenance	11. Moving Assistance 12. Non-Medical Transportation 13. Personal Assistance Services – Level 1 (PA-1) - 14. Personal Assistance Services – Level II (PA-2) - 15. Personal Assistance-Level 2 Delegated (PA-2 Delegated) 16. Personal Emergency Response System (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 (ICF/SNF)	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)	8. High Blood Pressure 9. HIV/AIDS 10. Seizures 11. Shortness of Breath 12. Transplant

STATE OF HAWAII
 Long Term Services and Support (LTSS)
 ADULT LTSS ASSESSMENT TOOL
 18 years and older

6. Heart Disease 7. Hepatitis B/C	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 Developmental 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 Assistance 28. PERS Personal Emergency Response System 29. PCP Primary Care Provider 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