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

SECTION A. ADMINISTRATIVE INFORMATION

A1. Member

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

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

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

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:

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 ☐ iv. Indian ☐ vii. Laotian
  - ☐ ii. Chinese ☐ v. Japanese ☐ viii. Vietnamese
  - ☐ iii. Filipino ☐ vi. Korean ☐ ix. Other
- ☐ 4. Caucasian
- ☐ 5. Hispanic or Latino
- ☐ 6. Native Hawaiian or other Pacific Islander
  - ☐ i. Federated State of Micronesia ☐ v. Samoan
  - ☐ ii. Native Hawaiian ☐ vii. Tongan
  - ☐ iii. Palauan ☐ vii. Other
  - ☐ iv. Marshallese
- ☐ 7. Other:

B2. Communication

a. Primary Means of Communication ☐ 1. Verbal ☐ 3. Written ☐ 5. Other:
☐ 2. Non Verbal ☐ 4. American Sign Language

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. Nursing Facility (NF)
- ☐ 6. Rehabilitation hospital/unit
- ☐ 7. Psychiatric hospital/unit
- ☐ 8. Acute care hospital
- ☐ 9. 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. HCBS Services

a. List HCBS Services

HCBS Service	Provider/Agency	Frequency	Comments

C6. Institutional Services

a. List Institutional Services

Institution 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*****

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:

C10. Prevention

a. Prevention
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. Date of last TB Chest X-ray / /

b. Comments:

C11. Immunizations

a. Immunizations

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

b. Comments:

C12. Personal Beliefs

a. Personal Beliefs
1. Do you have any beliefs and/or concerns that may affect your acceptance of health care assistance, treatments, or procedures? ☐ Yes ☐ No
2. If yes, explain.

b. Comments:

SECTION D. PERSON CENTERED INFORMATION

D1. Personal Interview

a. Personal Interview
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 you needs and concerns?

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

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

b. Comments:

D2. Finances

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

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

b. Comments:

D3. Social Supports

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

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

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

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

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

							☐ Yes ☐ No	☐ Yes ☐ No		
							☐ Yes ☐ No	☐ Yes ☐ No		

3. Strong and supportive relationship with family? ☐ Yes ☐ No

b. Comments:

D4. Parents/Primary Caregiver

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

a. Parents/Primary Caregiver Status

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

b. Comments:

SECTION E. GENERAL HEALTH

E1. Birth History

a. Birth History

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

b. Comments:

E2. Vision, Hearing, Speech, Expression and Comprehension

a. Vision

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

b. Hearing

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

c. Speech

1. Speech pattern
   - ☐ i. Coherent
   - ☐ ii. Incoherent

d. Expression

1. Ability to verbally express ideas
   - ☐ i. Understood
   - ☐ ii. Usually understood

e. Comprehension

1. Ability to understand others
   - ☐ i. Understands
   - ☐ ii. Usually understands

☐ iii. No speech 2. Date of LAST Speech Evaluation / /	☐ iii. Sometimes understood ☐ iv. Rarely or never understood	☐ 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

E4. Mood, Behavior, and Psychological Well Being

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

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

	Never (0)	Sometimes (1)	Often (2)
1. Feels sad, unhappy	☐	☐	☐
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 significant happened recently that impacts your child's life? ☐ Yes ☐ No
2. If yes, please identify.

e. Comments:

E5. Functional Status

a. Activities of Daily Living (ADLs)

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

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

c. Comments:

E6. Health Condition

a. Vitals
1. Temperature _____ F
   i. Mode
2. Pulse _____ bpm
   i. Mode
3. Respirations _____ per min
4. Oxygen Saturation _____%
   i. Mode
5. Blood Pressure _____/_____
   i. Location:
   ii. Position:
   iii. Usual blood pressure range
   - / -

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

c. Fall History
1. Fall(s) within the last 30 DAYS
   ☐ Yes ☐ No
2. Fall(s) within the past 31-90 DAYS
   ☐ Yes ☐ No

d. 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:

e. Comments:

E7. 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
   If no, explain.
3. Dietary Modifications, if applicable
   ☐ i. Normal
   ☐ ii. Minced
   ☐ iii. Pureed solids
   ☐ iv. Thickened liquids
4. Do you require enteral feedings? ☐ Yes ☐ No
   ☐ i. Nasogastric (NG) Tube
   ☐ ii. Gastrostomy Tube (GT)
   ☐ iii. Gastro/Jeujonostomy (G/J) Tube
5. Do you require parenteral feedings? ☐ Yes ☐ No
   ☐ i. Total Parenteral Nutrition (TPN)
   ☐ ii. Other, parenteral feeding:

f. Comments:

E8. Continence

a. Continence

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

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

c. Comments:

E9. 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:

E10. 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:

E11. Pregnant Female **(Complete this section if member is a pregnant female)**

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

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 supports 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 F11. Shortness of Breath.

F1. Asthma

a. Asthma

1. Briefly describe your current respiratory symptoms.
2. Are your symptoms getting better or worse in the last 12 months?
3. Do you use a peak flow meter? ☐ Yes ☐ No
4. How often do you use a peak flow meter?
5. Do you have a rescue inhaler? ☐ Yes ☐ No
6. How often do you use your rescue inhaler?
7. Do you use a nebulizer? ☐ Yes ☐ No
8. How often do you use your nebulizer?
9. Do you know what triggers your respiratory condition? ☐ Yes ☐ No
10. List your respiratory triggers.
11. Are you having difficulty sleeping at night due to respiratory symptoms? ☐ Yes ☐ No
12. Do you have difficulty performing activities of daily living (ADLs) due to respiratory symptoms? ☐ Yes ☐ No
13. If yes, do you receive help from family or is there a plan in place for managing your respiratory condition? Explain. ☐ Yes ☐ No
14. Explain your plan.

b. Comments:

F2. Cancer

a. Cancer

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

b. Comments:

F3. Diabetes

a. Diabetes

1. Briefly describe your current symptoms related to your diabetes.
2. Do you currently monitor your blood sugar levels? ☐ Yes ☐ No
3. How often is blood sugar being monitored?
4. What is your usual blood sugar range? ______-______
5. What is your Glycohemoglobin or A1C level?
6. Has your doctor set a goal for your blood sugar range? ☐ Yes ☐ No
7. What is your doctor's recommended blood sugar range? ______-______
8. Is there a plan in place for managing blood sugar levels? ☐ Yes ☐ No
9. If yes, explain.
10. Are you on insulin? ☐ Yes ☐ No
11. If yes, how do you administer your insulin, e.g., Injections, pump.
12. Do you sense when your blood sugar levels are low? ☐ Yes ☐ No
13. If yes, what are your symptoms?
14. Do you sense when your blood sugar levels are high? ☐ Yes ☐ No
15. If yes, what are your symptoms?
16. How do you manage your low blood sugar levels?

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: ☐ Yes ☐ No
   - 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 or supports 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 supports? ☐ Yes ☐ No
4. Do you need further support? ☐ Yes ☐ No
5. If no, do you anticipate needing support 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 support 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. What type of transplant?
3. Describe your current status.

b. Comments:

SECTION G. TRANSPORTATION

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

a. Assessor Determination

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

b. Transportation

1. Current Mode of Transportation (Select all that apply)
   - ☐ i. Family vehicle

- ☐ ii. Friend's vehicle
- ☐ iii. Public transportation
  - ☐ a. Bus
  - ☐ b. Handi van
- ☐ iv. Van
  - ☐ a. Curb to curb
  - ☐ b. Door to door
  - ☐ c. Gurney
- ☐ v. Taxi
- ☐ vi. Air Travel for specialist care
- ☐ vii. Other:

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

c. Comments:

SECTION H. HOME ENVIRONMENT

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

a. Current Home

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

	Adequate	Inadequate	N/A	Comments
b. Exterior Assessment				
Walkways free of clutter	☐	☐	☐	
Ramps/handrails safe	☐	☐	☐	#Exits ☐ Accessible Locations

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

I. EMERGENCY PLANNING

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

a. Emergency Contact(s)

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

b. Emergency Plan

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

c. Comments:

SECTION J. MEMBER NEEDS

J1. Treatments and Therapy Needs

a. List Treatment and Therapy Needs

Treatment/Therapy(ies)	Frequency	Comments

J2. Medical Equipment and Supply Needs

a. List Medical Equipment and Supply Needs

Medical Equipment/Supply(ies)	Type/Description	Comments

J3. HCBS Needs

a. List HCBS Service(s) Needs

HCBS Service(s)	Frequency	Comments

J4. Institutional Needs

a. List Institutional Needs

HCBS Service(s)	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. 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
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) 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
8. High Blood Pressure

2. Cancer
3. Chronic Obstructive Pulmonary Disorder (COPD)
4. Diabetes
5. End Stage Renal Disease (ESRD)
6. Heart Disease
7. Hepatitis B/C
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 Disable Division
15. **DHS** Department of Human Services
16. **DOE** Department of Education
17. **DOH** Department of Health
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
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