Foster Care Health Risk Screener

SECTION 1: MEMBER AND CAREGIVER INFORMATION			
Anthem ID #		**Medicaid ID #**	
Child Welfare Identifier Personal ID if applicable			
Member Date of Birth			
Child's First Name		**Child's Last Name**	
Child's Race/Ethnicity			
Language Preference			

Name of Legal Guardian	
Name of Caregiver or Foster Parent	
Person Completing this health risk screening/Relationship	
Relationship of person to child	
Current Placement Type	
Address	
Preferred contact number Home, Cell, other	
Email address	
Are you ok with us using this email to contact you?	

SECTION 2: CURRENT HEALTH STATUS			
1) Child's Height		**2) Child's Weight**	
3) Does the child have any of the following Physical Health conditions?		**4) Does the child have any of the following Behavioral Health diagnosis or needs?**	
Allergies	☐	ADHD	☐
Asthma	☐	Anxiety	☐
Breathing Problems	☐	Behavioral/Mental Health Needs	☐
Cancer	☐	Bipolar Disorder	☐
Congestive Heart Failure	☐	Conduct Disorder	☐
COPD	☐	Depression	☐
Diabetes	☐	Oppositional Disorders	☐
Digestive Problems	☐	Psychotic Disorders	☐
Eating Disorder	☐	Post-traumatic Stress Disorder (PTSD)	☐
Epilepsy/Seizures	☐	Schizophrenia/Psychosis	☐
Heart Disease	☐	Substance Use Disorder	☐
Hepatitis B	☐	Other Behavioral Health Diagnosis not listed?	☐

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Hepatitis C	☐
High Blood Pressure	☐
HIV/Aids	☐
Kidney failure	☐
Multiple Sclerosis/MS	☐
Obesity	☐
Quadriplegia	☐
Sickle Cell	☐
Stroke	☐
Other Physical condition not listed	☐

Does the child have any **Development disability, Developmental delay or needs**? If Yes, check the following: ☐ Yes ☐ No

Autism Spectrum Disorder	☐
Intellectual Delay	☐
Language and Speech Delay	☐
Motor development delay such as not sitting, walking or crawling	☐
Other Developmental conditions not listed above? _____	

5). If yes to any of these conditions: Is the child currently receiving services for this condition?

_____

_____

_____

6). If Female and 12 years or older: Is the member Pregnant? ☐ Yes ☐ No

7). If Yes, what is the due date? _____

_____

_____

SECTION 3: CURRENT HEALTH SERVICES

Services

Is the child currently receiving any of the following Services?

Service	Yes/No (check one)	How often	Does the child/parent/caregiver know how to use the equipment or supplies?	Name of Provider
Speech Therapy	Yes ☐ No ☐			
Physical Therapy	Yes ☐ No ☐			
Occupational Therapy	Yes ☐ No ☐			
Rehab Services	Yes ☐ No ☐			
Dialysis	Yes ☐ No ☐			
Chemotherapy/Radiation Therapy	Yes ☐ No ☐			

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Home Health Services	Yes ☐ No ☐			
Behavioral/Mental Health Services	Yes ☐ No ☐			
Substance Use Services	Yes ☐ No ☐			
Counseling or therapy for an emotional or psychological issue	Yes ☐ No ☐			

Medical Equipment & Supplies		
Does the child have or use any of the following medical equipment or supplies?		Name of Supplier (vendor)
Wound Supplies	☐	
Wheelchair	☐	
Oxygen	☐	
Specialty Bed	☐	
Feeding Pump	☐	
Insulin Pump	☐	
Mechanical Lift	☐	
Breathing Machine (CPAP, BiPAP, Ventilator, Nebulizer)	☐	
Blood Glucose Meter	☐	
Other (please list) _____		
Is the child waiting for equipment/supplies?	☐ Yes ☐ No	
Does the child use medical care, home health or other health services at least once every three months?	☐ Yes ☐ No	

Primary Care

PCP Name _____
PCP Phone number _____
PCP Address _____
Date of Last visit to the PCP _____

Dentist & Vision

Dentist Name _____
Dentist Phone number _____
Dentist Address _____
Date of Last visit to the Dentist _____
Vision doctor name _____
Vision doctor number _____
Vision doctor address _____
Date of last visit to Vision doctor? _____

Specialist

Specialist name _____
Specialist number _____
Specialist phone _____
Type of specialist _____
Date of last visit to specialist _____

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Medications

Does the child use one or more prescriptions? Yes ☐ No ☐

If Yes, please list Condition, Medication, How often? _____

Is the child able to take medications as prescribed and instructed by their doctor? ☐ Yes ☐ No

Does the child have immediate need for a refill on any medications? ☐ Yes ☐ No

Does the child have any allergies to any medications, or anything else? ☐ Yes ☐ No

If Yes, List allergies _____

Pharmacy Name _____

Pharmacy Phone Number _____

Immunizations, Exams and Screenings

Is the child up to date on your immunizations? ☐ Yes ☐ No ☐ I'm not sure

Has the child had a flu shot in the last 12 months? ☐ Yes ☐ No ☐ I'm not sure

Has the child had an eye exam in the last 12 months? ☐ Yes ☐ No ☐ I'm not sure

Has the child had a hearing exam in the last 12 months? ☐ Yes ☐ No ☐ I'm not sure

If ages 0-5, has the child undergone a developmental Screening? ☐ Yes ☐ No ☐ I'm not sure

Do you have concerns for the child's development? _____

Hospital, Emergency Room

Have the child stayed overnight in the hospital in the last 12 months? ☐ Yes ☐ No

If Yes, reason for admission _____

Date of last Admission _____

Have the child recently been seen in the Emergency Room? ☐ Yes ☐ No

If YES, what was the reason for the emergency room visit? _____

Date of recent ER visit _____

Current Conditions _____

SECTION 4: MENTAL HEALTH AND BEHAVIORAL HEALTH STATUS

Has the child received a trauma assessment? ☐ Yes ☐ No Date _____

If no, is there one scheduled?

Do you have concerns for the child's mental health and well-being? ☐ Yes ☐ No

Does the child have exhibit behaviors that are concerning to you? ☐ Yes ☐ No ☐ N/A

Does the child currently exhibit behaviors that are difficult to maintain them in their current living or educational setting? ☐ Yes ☐ No

Does the child have a history of exhibiting bizarre or difficult behaviors?

☐ Yes ☐ No

Is the child having thoughts of hurting him or herself or someone else? If Yes, Follow Crisis Call Procedure

☐ Yes ☐ No

Does the child have a history of being a danger to themselves or others?

☐ Yes ☐ No ☐ N/A ☐ Unknown

Foster Care Health Risk Screener

Does the child have an immediate need for psychotropic medication consultant and/or prescription refill? (Either needs immediate evaluation of medication or needs a new prescription)

☐ Yes ☐ No ☐ N/A ☐ Unknown

Over the last 2 weeks, has the child been bothered by feeling down, depressed or hopeless? *(pick one)*

☐ Not at all ☐ Nearly every day ☐ Several days ☐ More than half the days ☐ N/A

Over last 2 weeks, has the child been bothered by little interest or pleasure in doing things? *(pick one)*

☐ Not at all ☐ Nearly every day ☐ Several days ☐ More than half the days ☐ N/A

Substance Use

1). Has the child used substances or drugs, other than those required for medical reasons?

☐ Alcohol
☐ Marijuana
☐ Stimulants
☐ Sedatives (Xanax, sleeping pills)
☐ Opioids (Heroin, Codeine, Morphine, Methadone)
☐ Prescription medication
☐ Tobacco products
☐ Cocaine
☐ PCP
☐ Inhalants
☐ Psychedelics
☐ Other

2). Has the child taken medications that helped them detox from other substances? Suboxone, Methadone ☐ Yes ☐ No

3). Is the child feeling physical discomfort due to drug or alcohol use? ☐ Yes ☐ No (If Yes follow crisis procedure)

SECTION 5: SOCIAL DETERMINANTS OF HEALTH

Do you or the child need assistance with the following?

☐ Food	☐ Child	☐ Caregiver
☐ Clothing	☐ Child	☐ Caregiver
☐ Housing	☐ Child	☐ Caregiver
☐ Mobility	☐ Child	☐ Caregiver
☐ Getting to medical appointments	☐ Child	☐ Caregiver
☐ Safety	☐ Child	☐ Caregiver
☐ Employment	☐ Child	☐ Caregiver

Education

Is the child currently enrolled in school? ☐ Yes ☐ No ☐ Too young

If no please list reason? Too Young, suspended, dropped out? _____

If Yes, Current Grade Level?

_____

Does the child have a 504 Plan? ☐ Yes ☐ No ☐ Unknown

Does the child have an IEP? ☐ Yes ☐ No ☐ Unknown

Foster Care Health Risk Screener

Caregiver Section

As a caregiver are you experiencing:

- ☐ Feeling overwhelmed? If Yes please explain
- ☐ Emotional strain? If Yes please explain
- ☐ Financial strain? If Yes please explain
- ☐ Isolation? If Yes please explain

Closing

Is there any other concern you would like our care team to reach out to you for?

_____
_____
_____

Children Identified as Receiving Enteral Therapy Screening for Care Coordination/Case Management

GENERAL INFORMATION	
First Name:	Click here to enter text.
Last Name:	Click here to enter text.
Member ID Number:	Click here to enter text.
Birthdate:	Click here to enter a date.
Plan:	Click here to enter text.
Product Info:	Click here to enter text.
Street Address:	Click here to enter text.
City:	Click here to enter text.
State:	Click here to enter text.
County:	Click here to enter text.
Zip Code:	Click here to enter text.
Home Phone:	Click here to enter text.
Individual providing information for the assessment:	☐ Parent ☐ Guardian ☐ Caregiver ☐ Other
If Other, explain and/or list name here as appropriate"	Click here to enter text.
Does your child have any other health insurance?	☐ Yes ☐ No ☐ Unknown
If yes, please provide name and/or describe	Click here to enter text.

WAIVER SERVICES		
Does your child participate in a waiver program?	☐ Yes ☐ No ☐ Unknown	
If Yes, please describe:	Click here to enter text.	
Is your child receiving any of the following services?	☐ 1- Skilled Nursing Visit ☐ 2- Private Duty Nursing ☐ 3- Personal Care Assistant ☐ 4- Hospice/Palliative Care ☐ 5- PT ☐ 6- OT ☐ 7- ST ☐ 8- Early Childhood Interventions ☐ 9- WIC	☐ 10- School Based Services/ Programs ☐ 11- Faith Based Support ☐ 12- SSI ☐ 13- State/Federal Care Coordination- Assistance Services ☐ 14- Behavioral therapist ☐ 15- None ☐ 16- Other ☐ 17- Services Needed
If Other, None, or Services Needed please describe:	Click here to enter text.	

Children Identified as Receiving Enteral Therapy Screening for Care Coordination/Case Management

PCP/IMMUNIZATIONS/WELL VISITS/EPSDT/SPECIALISTS		
Has your child seen their PCP in the last year? (Example medical home, primary care provider coordinating care etc.)	☐ Yes ☐ No ☐ Unknown	
Has the child received all age appropriate immunizations (including Synagis and Flu) and Well Visits/EPSDT screenings (to include lead screening as appropriate)?	☐ Yes ☐ No ☐ Unknown	
If No or Unknown, please explain:	Click here to enter text.	
Does your child see a specialist?	☐ 1-Audiology ☐ 2-Allergy & Immunology ☐ 3-Cardiology ☐ 4-Dermatology ☐ 5-Endocrinology ☐ 6-Diagnostic Radiology ☐ 7-Dietician/Nutritionist ☐ 8-Ear-nose-throat ☐ 9-Gastrointestinal ☐ 10-General surgery ☐ 12-Hematologist ☐ 13-Immunologist	☐ 14-Infectious Disease ☐ 15-Genetics ☐ 16-Nephrology ☐ 17-Neurodevelopment ☐ 18-Neurologist ☐ 20-Ophthalmologist ☐ 21-Orthopedic ☐ 22- Psychiatrist ☐ 23-Urologist ☐ 24-Other ☐ 25- No Specialist required/needs met by Primary Care Providers ☐ 26- Needs a specialist
If Other or Needs a Specialist, please describe here:	Click here to enter text.	

HOSPITAL/ER LAST 6 MONTHS	
Has your child required hospitalization in the last 6 months?	☐ No ☐ Yes, one time ☐ Yes, two or more times ☐ Unknown
Has your child visited the Emergency Room in the last 6 months?	☐ No ☐ Yes, one time ☐ Yes, two or more times ☐ Unknown
If Unknown, Please explain:	Click here to enter text.

Children Identified as Receiving Enteral Therapy Screening for Care Coordination/Case Management

NUTRITION/PROVIDERS OF CARE FOR ENTERAL FEEDING TUBE	
How does your child receive their nutrition?	☐ 1-Age appropriate diet/by mouth ☐ 2-Nasogastric Tube ☐ 3-Gastrostomy Tube ☐ 4-Jejunostomy Tube ☐ 5-Esophagostomy Tube ☐ 6-Parenteral/Intravenous/TPN ☐ 7-Other
If Other, explain:	Click here to enter text.
Please describe the providers of care for your child's enteral feeding tube care? (choose all that apply):	☐ 1- Pediatrician/Primary Care ☐ 2- Hospital Emergency ☐ 3- Dietician/Nutritionist ☐ 4- Gastrointestinal ☐ 5- General surgery ☐ 6-Diagnostic Radiology ☐ 7- Feeding Clinic or Specialist ☐ 8- None ☐ 9- N/A ☐ 10-Other ☐ 11- Unknown
If None, N/A, Other, or Unknown, please explain and/or provide detail as needed:	Click here to enter text.

DIFFICULTY OBTAINING MEDICINE/HEALTH OR SOCIAL SUPPORT NEEDS		
If your child is on any medication, are you having any difficulty getting medications or giving the medications as prescribed?	☐ Yes, getting medications ☐ Yes, giving medications ☐ No ☐ N/A- No medications prescribed	
If yes, please describe:	Click here to enter text.	
Do you have any of the following health or social support needs and/or concerns for your child?	☐ 1-Car/Booster Seat ☐ 2-Crib ☐ 3-Clothing ☐ 4- Cultural/language barriers ☐ 5- Finances ☐ 6- Food ☐ 7- Health education deficits ☐ 8- Housing issues ☐ 9- Inadequate social support ☐ 10- Family relationships or dynamics	☐ 11- Pharmacy ☐ 12- Safety ☐ 13- Transportation ☐ 14- Utilities (Electric, Gas, Water) ☐ 15- Transition to adulthood ☐ 16- Other ☐ 17- No social concerns noted
If Other, explain:	Click here to enter text.	

Children Identified as Receiving Enteral Therapy Screening for Care Coordination/Case Management

TOTAL SCORE	
Total Score:	Click here to enter text.

Care Coordination/Complex Case Management
Screener Scoring:

Score 0: (to also include, but not limited to Parent/Guardian refuses, No needs identified, no longer eligible etc.): Close case

Score 1 or 2: Case to remain open to Care Coordination

Score of ≥ 3: Close Care Coordination case and open new case to Complex Case Management (complete GBD CM Pediatric Assessment)

Please Note: Case Manager to consult with manager/medical director if the recommended scoring and follow up does not meet with clinical judgement standards.

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 7 - Strongly agree
- 6 - Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

____ In most ways my life is close to my ideal.

____ The conditions of my life are excellent.

____ I am satisfied with my life.

____ So far I have gotten the important things I want in life.

____ If I could live my life over, I would change almost nothing.

- 31 - 35 Extremely satisfied
- 26 - 30 Satisfied
- 21 - 25 Slightly satisfied
- 20 Neutral
- 15 - 19 Slightly dissatisfied
- 10 - 14 Dissatisfied
- 5 - 9 Extremely dissatisfied

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SELF-SUFFICIENCY MATRIX – 15 Domains

	1	2	3	4	5
Domain: FAMILY RELATIONS	Lack of necessary support from family or friends; abuse (DV, child) is present or there is child neglect	Family/friends may be supportive but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect	Some support from family/friends; family members acknowledge and seek to change negative behaviors; and learning to communicate and support	Strong support from family or friends; household members support each other's efforts	Has healthy/expanding support network; household is stable and communication is consistently open

Please review the topic and answer the following questions to the best of your ability:
According to this scale, I feel I am **currently** at Level _____ (1-5).
Please Explain: _____
In **30 days**, I would like to be at Level _____ (1-5). Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 1 Intervention		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier Intervention		

Comments/Updates: _____

	1	2	3	4	5
Domain: HOUSING	Homeless; couch surfing; living in transitional housing or temporary shelter	Households with an eviction notice; or living in overcrowded or unsafe housing	Living in affordable private housing (50% or less of household income spent on housing); living in subsidized housing	Safe and secure homeownership or non-subsidized rental housing, choice limited by moderate income	Homeownership or secure rental housing in a neighborhood of choice

Please review the topic and answer the following questions to the best of your ability:
According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

Comments/Updates: _____

	1	2	3	4	5
Domain: EMPLOYMENT	No job, unwilling and/or unable to become employed due to significant barriers	No job, willing and able to become employed within 30 days	Temporary, part-time, or seasonal; inadequate pay; no benefits	Employed full time with inadequate income and few or no benefits	Maintains permanent employment with adequate income and benefits

Please review the topic and answer the following questions to the best of your ability:
According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

Comments/Updates: _____

	1	2	3	4	5
Domain: INCOME	No income	Inadequate income and/or spontaneous or inappropriate spending	Can meet basic needs with subsidy; appropriate spending	Can meet basic needs and manage debt without assistance	Income is sufficient, well managed; has discretionary income and is able to save

Please review the topic and answer the following questions to the best of your ability:

According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

Comments/Updates: _____

	1	2	3	4	5
Domain: TRANSPORTATION	No access to transportation, public or private; may have car that is inoperable	Transportation is available but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.	Transportation is available and reliable but limited and/or inconvenient; drivers are licensed and minimally insured	Transportation is generally accessible to meet basic travel needs	Transportation is readily available and affordable; drivers is licensed, car is adequately insured

Please review the topic and answer the following questions to the best of your ability:
According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

Comments/Updates: _____

	1	2	3	4	5
Domain: ADULT EDUCATION	Literacy problems and/or no high school diploma/GED are serious barriers to employment; not willing able to increase educate to contribute to increased employment/income	No high school diploma/GED	Has high school diploma/GED	Needs additional education/training to improve employment situation; willing and able to obtain additional education/training; and/or to resolve literacy problems to where they are able to function effectively in society	No literacy problems; has completed education/training needed to become employable to maintain permanent housing

Please review the topic and answer the following questions to the best of your ability:

According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

Comments/Updates: _____

	1	2	3	4	5
Domain: HEALTHY BEHAVIOR	Exhibits poor healthy behaviors; poor hygiene; poor eating habits; poor dental care; chain smoker, self-diagnosing – no regular or preventative doctor care	Bathing regularly, eating better but not assisting with food preparation, scheduling doctor appointments	Attends cooking classes; assists with shopping for ingredients to prepare meals; much improved personal hygiene, reducing tobacco use, becoming more physically active, receiving preventative screenings	Helps to prepare meals, seeking assistance to quit or reduce use of tobacco, pursuing exercise opportunities	Actively pursuing healthy lifestyle by exhibiting good personal hygiene, eating well-balanced healthy meals including fruits and vegetables, regular exercise and tobacco free, regular doctor visits for preventive and on-going care

Please review the topic and answer the following questions to the best of your ability:
According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

Comments/Updates: _____

	1	2	3	4	5
Domain: MENTAL HEALTH (DIAGNOSED OR OTHERWISE)	Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems	Recurrent mental health symptoms that may affect behavior but not a danger to self/others; persistent problems with functioning due to mental health symptoms	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning	Symptoms are absent or rate; good or superior functioning in wide range of activities; no more than everyday problems/concerns

Please review the topic and answer the following questions to the best of your ability:
According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

Comments/Updates: _____

	1	2	3	4	5
Domain: SUBSTANCE ABUSE (DIAGNOSED OR OTHERWISE)	Meets criteria for severe abuse; resulting problems so severe that institutional living or hospitalization may be necessary	Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities	Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems that have persisted for at least one month	Client has used during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use	No drug use/alcohol abuse in last 6 months

Please review the topic and answer the following questions to the best of your ability:

According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

Comments/Updates: _____

	1	2	3	4	5
Domain: LIFE SKILLS	Unable to meet basic needs such as hygiene, food, activities of daily living	Can meet a few but not all needs of daily living without assistance	Can meet most but not all daily living needs without assistance	Able to meet all basic needs of daily living without assistance	Able to provide beyond basic needs of daily living for self

Please review the topic and answer the following questions to the best of your ability:

According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Action 3		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Action 3		

Comments/Updates: _____

	1	2	3	4	5
Domain: FINANCIAL LITERACY	No income, no financial literacy training	Attends financial literacy training programs	Completes financial literacy training program and obtains certificate of completion	Obtains source of income and completes budget training; utilizes free tax preparation services	Able to maintain budget to meet financial responsibilities and save money

Please review the topic and answer the following questions to the best of your ability:
According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

Comments/Updates: _____

	1	2	3	4	5
Domain: CHILDCARE	Needs childcare, but none is available/accessible and/or child is not eligible, will effect housing stability	Childcare is unreliable or unaffordable; inadequate supervision is a problem for childcare that is available, will affect housing stability	Affordable subsidized childcare is available but limited, may affect housing stability	Reliable, affordable childcare is available, no need for subsidy, housing stability not affected	Able to select quality childcare of choice, housing stability no affected, no children in the household

Please review the topic and answer the following questions to the best of your ability:
According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

Comments/Updates: _____

	1	2	3	4	5
Domain: PARENTING SKILLS	There are safety concerns regarding parenting skills	Parenting skills are minimal	Parenting skills are apparent but not adequate	Parenting skills are adequate	Parenting skills are well-developed

Please review the topic and answer the following questions to the best of your ability:
According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

Comments/Updates: _____

	1	2	3	4	5
Domain: FOOD	No food or means to prepare it; relies to a significant degree on other sources of free or low-cost	Receiving food stamps	Can meet basic food needs but requires occasional assistance	Can meet basic food needs without assistance	Can choose to purchase any food desired

Please review the topic and answer the following questions to the best of your ability:
According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

Comments/Updates: _____

	1	2	3	4	5
Domain: **JOB TRAINING/VOCATIONAL REHABILITATION**	Unable to work; in the process of applying for disability or receiving disability	No job training; no plan or career goals	Attending employment counseling to determine career interests	Working with job counselor to build resume, job application, and interview skills	Receiving additional job or career training

Please review the topic and answer the following questions to the best of your ability:
According to this scale, I feel I am **currently** at Level _____ (1-5).

Please Explain: _____

In **30 days**, I would like to be at Level _____ (1-5).

Please explain: _____

Below is my Action Plan with concrete steps I can take to achieve this Goal.

Short Term (One Month) Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

In **90 days** I would like to be at Level _____ (1-5).

Please explain: _____

Long Term Goal: _____ Date Completed

Action 1		
Action 2		
Barrier 1		
Barrier 2		

Comments/Updates: _____

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KY Workforce/Social Determinant of Health Assessment

KENTUCKY WORKFORCE/SOCIAL DETERMINANT OF HEALTH ASSESSMENT

Introduction: This assessment will help us find activities that may be right for you. <We will walk through your level of school, work status, other helpful information. I will provide you an outline that will guide your next steps in meeting your goals. It should take no longer than 10-15 minutes.> Our conversation will not have any effect on your benefits or coverage. Anthem Medicaid does not discriminate based on race, color, national origin, age, disability, sex or gender identity.

Age Confirm member's age	Click here to enter text.
Highest level of education	
What is your highest level of education?	☐ 1- Less than high school ☐ 2- High school degree or equivalent ☐ 3- Some college but no degree ☐ 4- Associate degree ☐ 5- Bachelor's Degree ☐ 6- Graduate Degree ☐ 7- Technical/vocational training or certificate
Less than high school I Are you taking GED classes?	☐ Yes ☐ No
Less than high school II Do you want to take GED classes?	☐ Yes ☐ No
Taking classes Are you taking any classes?	☐ Yes ☐ No
Desire to attend college / take technical or certification classes	
Do you want to go to college or take technical or certification classes?	☐ Yes ☐ No
Assistance needed	
Do you need help reading the newspaper or websites?	☐ Yes ☐ No
Do you have trouble understanding things you read?	☐ Yes ☐ No
Do you want to learn how to read or learn better reading skills?	☐ Yes ☐ No
Work status I	
Do you work?	☐ Yes ☐ No
Work status II- Working	
Do you work 20 or more hours per week?	☐ Yes ☐ No
Work status III -Not Working	
Are you looking for work?	☐ Yes ☐ No
Since you are not already working, do you feel you are ready to work and have the skills you need to find a job?	☐ Yes ☐ No

KY Workforce/Social Determinant of Health Assessment

Job training or apprentice program / volunteer or public service	
Are you in job training or an apprentice program?	☐ Yes ☐ No
Do you volunteer or do public service?	☐ Yes ☐ No
Exemptions	
Are you a full-time college student?	☐ Yes ☐ No
Are you a primary caretaker for a child living in your home under the age of <19 years> or for a disabled tax dependent in the household?	☐ Yes ☐ No ☐ Prefer not to say
Are you pregnant?	☐ Yes ☐ No ☐ Prefer not to say
Are you homeless or not have stable housing?	☐ Yes ☐ No ☐ Prefer not to say
Are you worried that in the next <two months>, you may not have stable housing?	☐ Yes ☐ No ☐ Prefer not to say
Are you in substance abuse or addiction treatment?	☐ Yes ☐ No ☐ Prefer not to say
Do you have chronic or complex health issues that keep you from going to work or school?	☐ Yes ☐ No ☐ Prefer not to say
Are you or in the last <30 days> have you been in a hospital or facility for more than <one day>, in a domestic violence shelter, or other temporary housing location?	☐ Yes ☐ No ☐ Prefer not to say
Are you a former foster youth up to <26 years old>?	☐ Yes ☐ No ☐ Prefer not to say
Do you receive Kentucky food stamps or Supplemental Nutritional Assistance Plan (SNAP) benefits?	☐ Yes ☐ No ☐ Prefer not to say
Do you receive Kentucky Transitional Assistance Program (KTAP) or cash assistance through Temporary Assistance for Needy Families (TANF)?	☐ Yes ☐ No ☐ Prefer not to say
Do you have problems completing activities of daily living such as feeding self, bathing self, dressing self.	☐ Yes ☐ No ☐ Prefer not to say
Food / Utility / Housing	
In the last <30 days>, did you ever eat less than you felt you should because there wasn't enough money for food?	☐ Yes ☐ No ☐ Prefer not to say
In the last <three months>, has your utility company shut off your service for not paying your bill?	☐ Yes ☐ No ☐ Prefer not to say

KY Workforce/Social Determinant of Health Assessment

Children	
Do you have children?	☐ Yes ☐ No ☐ Prefer not to say
Child Care Issues	
Do problems getting child care make it difficult for you to work or study?	☐ Yes ☐ No ☐ Prefer not to say
Transportation Issues	
Do you lack reliable transportation to get to work, school, or volunteer opportunities?	☐ Yes ☐ No ☐ Prefer not to say
Cell Phone / Internet	
Do you have access to a cell phone?	☐ Yes ☐ No
Do you have access to the internet?	☐ Yes ☐ No
Legal Problems	
Do you have any legal issues such as a criminal record, debt collections, or other court proceedings that prevent you from working or going to school?	☐ Yes ☐ No ☐ Prefer not to say
Work History	
What's the longest you've held a job?	☐ Never been employed ☐ Less than one year ☐ One year or longer
If you had a previous job or have done volunteer work in the past, how would your supervisor rate your performance?	☐ Below average ☐ Average ☐ Above average ☐ N/A
Hobbies / favorite subjects in school / free time	
Do you have hobbies that you enjoy?	Click here to enter text.
Did you have any favorite subjects in school?	Click here to enter text.
What are ways that you fill your time when you are not working?	Click here to enter text.
Desired job / certifications of interest / volunteer	
Is there a job that you have always wanted to do?	Click here to enter text.
If so, do you know what kind of school or skills are needed for that job?	Click here to enter text.
Are there any certifications that interest you? (Cooking, CNA, medical coding, technical, construction, etc.)	Click here to enter text.
If you were to volunteer, where would like you like to volunteer?	Click here to enter text.

KY Workforce/Social Determinant of Health Assessment

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Anthem Blue Cross and Blue Shield Medicaid follows Federal civil rights laws. We don't discriminate against people because of their:

- Race
- Color
- National origin
- Age
- Disability
- Sex or gender identity

Do you need help with your health care, talking with us, or reading what we send you? We provide our materials in other languages and formats at no cost to you. Call us toll free at 1-855-690-7784 (TTY 711).

¿Necesita ayuda con su cuidado de la salud, para hablar con nosotros o leer lo que le enviamos? Proporcionamos nuestros materiales en otros idiomas y formatos sin costo alguno para usted. Llámenos a la línea gratuita al 1-855-690-7784 (TTY 711).

Benötigen Sie Hilfe bei Ihrer medizinischen Versorgung, der Kommunikation mit uns oder beim Lesen unserer Unterlagen? Unsere Materialien sind auf Anfrage auch in anderen Sprachen und Formaten kostenlos erhältlich. Rufen Sie uns gebührenfrei an unter 1-855-690-7784 (TTY 711).

Psychotropic Medication Screening Tool

PSYCHOTROPIC MEDICATION SCREENING TOOL	
Member Name:	Click here to enter text.
Member Age:	Click here to enter text.
Member #:	Click here to enter text.
Status:	Click here to enter a date.
Care Manager:	Click here to enter text.
Date:	Click here to enter text.
Diagnosis	Click here to enter text.

MEDICATION CHART		
Medications	**Dosage**	**Frequency**
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.

Medication Issues	Click here to enter text. *Describe any problems associated with adherence to the medication, if any.*
Medication Duration	Click here to enter text. *For the psychotropic drug that the member has been taking the longest, how long has the member been on this medication?*
Monitoring/Testing:	Click here to enter text. *Are appropriate monitoring/testing being conducted (i.e. EKG for lithium, weigh checks, lipid and metabolic panels.)*
Adjunct Services:	Click here to enter text. Is the member also receiving adjunct services as psychotherapy?
Additional Comments:	Click here to enter text.
For Medical Director Usage Only	
MD Comments	Click here to enter text.

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