#	Question/Text (* Indicates Mandatory)	Answer Options	*Talking Points - Guidance for Care Coordinator*	
	*Member Name:			
	Cell Phone: Other Phone:			
	*Today's Date:			
	*Person completing this assessment:	Adoptive Parent Biological Parent DCBS Worker Foster Parent Non-Relative Caregiver Relative Caregiver Other: _____		
	*Date of Needs Assessment completion:		Based on member's individualized needs and preferences, Care Coordination Staff will use the following talking points to assess member's safety, medical, behavioral health, cognitive and functional needs. CC Staff are asked to use their expertise to explore where appropriate when questions warrant further probing. Talking points serve as a guide to meet the member where they are at and identify the needs and preferences. All talking point outcomes that contain pertinent positives should be recorded in Question 56 or 62 as	
	*Verbal consent to participate in care management services was given by:	Member Legal Guardian POA Member Representative Other: _____		
	*Select the date consent was given:			
	*Verbal consent to share information with member's providers obtained, including the sharing of sensitive information for the purposes of care coordination. Sensitive information includes behavioral health, substance use disorder, HIV, sexual assault/traumatic events	Yes No		
	Assessment method:	Telephonic		
	*Assessment Type:	Initial Monthly Update Quarterly Update Annual Significant Change in Condition Caregiver Environment Health Income Living Situation		
1	*Do you or your child have a language preference other than English? If Other is selected, please specify.	Arabic Creole French Mandarin Russian Somali Spanish Vietnamese Sign language N/A Other: _____	Probe on needs related to language: Example- Written vs Spoken needs Document whether there is a family member or proxy to translate or member request to use language line If not reflected in systems, update per protocol.	
2	*Does your child need assistance with any of the following areas that you feel they should be able to do themselves at this age? If other, please list/describe.	Bathing Dressing Feeding Toileting Grooming Oral care Transferring Hearing or Communication device None Other: _____	Probe if child needs assistance: with any of the areas listed. - DME/Home Care - Financial and socioeconomic needs - Transferring is anything to do with movement (i.e. moving from lying down to standing)	
3	*Does your child or family have any religious and/or cultural beliefs that may influence your healthcare decisions? For example, are there any foods or medications you avoid? If other, describe.	Diet Medication Blood products Time Constraints Fear of Strangers None Other/Specify: _____	Probe on Cultural, Physical, Spiritual and Literacy needs and preferences: How is member is able to navigate their needs in the Physical, BH and LTSS domains to ensure needs are met and understood? What are their strengths in these areas? Any unmet needs that need to be addressed that will impact ability to get medications, medical tx, BH care or LTSS? Document all findings in section 20.	
	Health Overview			
4	*What is your child's main health concern right now? What is your main concern for your child right now? What worries you the most as a parent/guardian?		Probe on health or safety concerns: Any recent falls, injury or Trauma? Document findings and address needs in care plan and with member.	

5	*Does your child have any of these diagnoses/conditions?	ADHD Asthma Autism Behavioral Health Conditions: - Anxiety - Bipolar Disorder - Depression - Eating Disorder - Psychotic Disorders (Schizophrenia) - Substance Use Disorders (SUD) Birth Defect(s) Blood Disorder Cancer including past history Cerebral Palsy Chronic Pain Cystic Fibrosis Diabetes Type 1 Diabetes Type 2 Digestive or stomach problems Down's Syndrome Epilepsy / Seizure Disorder ESRD / Kidney disease / Dialysis	Probe on physical and Behavioral Health conditions and related special needs member may have: - Use clinical guideposts as appropriate-inquire about connection to services, medication and other areas of clinical criteria (BH, CHF, COPD, DM, HIV/AIDS) - Describe conditions and typical tx to help members understand question where needed - SUD- give an example such as smoking, alcohol or use of controlled medications not prescribed by a physician. Inquire whether member would like to quit? Note: If child is positive for SUD, promptly complete CRAFFT survey after completing this assessment.	
5 cont.	(diagnoses/conditions continued)	Heart Failure Hepatitis HIV / AIDS Intellectual / Developmental Disabilities Liver Disease Multiple Sclerosis (MS) Muscular Dystrophy (MD) NICU graduate Paraplegia / Quadriplegia Respiratory with oxygen Sickle Cell disease Spina Bifida / Neural tube defect Teen Pregnancy Tuberculosis None Other		
6	*Do you receive help at home caring for your child because of his/her health problems?	Yes No N/A Details: _____		
7	Are you receiving the help that you need?	Yes No N/A Details: _____		
8	*What service(s) is your child receiving?	24-hour supports from a Medicaid Waiver Provider Area Agency on Aging (AAA) Behavioral Health Services Chemotherapy Developmental Therapy Dialysis DME Home Health Agency Services Hospice Medical Care Occupational Therapy Physical Therapy PPEC Private Duty Nursing Prosthetic Fitting Radiation Therapy Rehabilitative Special Education Services Speech Therapy Substance Abuse None		
9	*Are you using any community resources?	Counseling Services Disability Food Bank Food Stamps Free Clothing Store Housing Legal Services Meals on Wheels SSI Support Groups Transportation Utility Services WIC None	Provide any information on additional community resources which may be of assistance to the enrollee.	

10	*I am going to read two statements to you, and I am going to ask you to tell me how you would rate each statement: Within the past 12 months, we worried whether our food would run out before we got money to buy more. Was that Often true, Sometimes true, or Never true for you?	Often true Sometimes true Never true Details: _____		
11	*Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Was that Often true, Sometimes true, or Never true for you?	Often true Sometimes true Never true Details: _____		
12	*What transportation help do you need with getting places, for example, to get to your doctor appointments or pharmacy?	Doctor appointments Pharmacy General needs (errands, groceries, etc.) Social activities None Other: _____ Details: _____		
13	*What is keeping you from getting places where you need to go?	Caregiver unavailability No personal transportation available No available public transportation Financial issues No access to handicap transportation N/A Other: _____		
14	*What trouble do you have paying for your monthly expenses such as rent, heating, or electric bills?	Trouble paying rent/mortgage Does not have housing, living with friends/family/hotel Does not have housing, living in car/shelter Heat/Electric Water None Other: _____		
15	*What kinds of care do you have problems accessing? For example, getting an appointment to see your PCP.	PCP appointments Specialty appointments Access to a vision provider HHC access Dental care Behavioral Health care Therapies (PT, OT, ST) Access to a Pharmacy None Other: _____ Details: _____		
16	*There are many things that can cause	Falling Easily based on Health		
17	*Does your child receive SSI? Gather information as to the reason/disability.	Yes No Details: _____		
18	**Regular Doctor or Clinic** *A regular doctor is the one your child would see if he/she needed a check-up, you want advice about a health problem, or your child gets sick or hurt. Do you have a regular doctor or clinic that you take your child to when he/she gets sick or hurt and	Yes No Details: _____		
19	*If Yes, has your child gone to see his/her regular doctor for a check-up in the last 3 months?	Yes No Date, if known: _____	Ensure child is being seen at the below required intervals. Offer a conference call with Pediatrician/PCP to schedule next appointment if needed. Periodicity Schedule Infancy -- < 1 month -- 2 months -- 4 months -- 6 months -- 9 months -- 12 months Early Childhood -- 15 months -- 18 months -- 24 months -- 30 months -- 3 years -- 4 years Middle Childhood -- 5 years -- 6 years -- 8 years -- 10 years	Adolescence -- 11 years -- 12 years -- 13 years -- 14 years -- 15 years -- 16 years -- 17 years -- 18 years -- 19 years -- 20 years

20	Lead Poisoning (Screens should be completed at 9 months and again at 24 months) Has your child (the member) ever been tested for lead poisoning?	Yes No Don't know	From the Office of the Administration for Children & Families: Talk with your health care provider about lead screening. Lead screening measures the level of lead in the blood through a blood test in the finger or vein. It is important. Lead is a toxin that is particularly dangerous for young children because of their small size and rapid growth and development. It can cause behavioral and learning difficulties, anemia, seizures and other medical problems. A lead test is the only way to know if your child has lead poisoning. Most children who have lead poisoning do not look or act sick. Talk to your doctor	
21	Have you ever been told your child (the member) had lead poisoning?	Yes No Don't know		
22	*Are immunizations up-to-date?	Yes No If No, Details: _____ Date of last Immunizatons, if known: _____	CDC Immunization Schedule: https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html	
23	*Has your child had a flu shot?	Yes No N/A, child is under 6 months of age If No, Details: _____ Date, if known:	The CDC recommends that everyone 6 months of age and older get a seasonal flu vaccine each year by the end of October. https://www.cdc.gov/flu/highrisk/children.htm	
24	*Has your child had hearing and vision tests?	Yes No If No, Details: _____ Date, if known: _____		
25	*Has your child had a Dental exam?	Yes No If No, Details: _____ Date, if known: _____	CDC Children's Oral Health: https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html	
26	*Do you have a list of all of your child's medications, including non-prescribed, over-the-counter, and supplements? Do you know why your child is taking them?	Yes No N/A Details: _____	If no: - If no, recommend "Brown Bag" medication intervention with PCP (bringing all the medications to the appointment) - Ask and coach on where the meds are kept and are they safely out of reach of the child? - Coach on putting all medications in a bag and have them take to PCP office. Ask them to have PCP/ nurse in PCP office to review each medication and why they are taking. - Make sure that physician appointment is in place.	
27	*Many families tell us that it is difficult to give children medicines every day or at the same time every day. In the last 7 days, has your child (the member) missed taking a dose of his/her medications?	Yes No N/A, child is not taking prescribed medications, over-the-counter medications, or supplements Details: _____		
28	**Assessment Team Participants:** List all individuals including full Name, Phone #, and Title/Role if not already specified.		Notate any persons who are associated with key components of the Foster Care assessment process. The purpose of the AT meetings is to review the outcome and recommendations related to the assessment of the FC Enrollee and family. The disciplines which may participate as part of the AT should include, but are not limited to the following: A. Legal custodian (DCBS professionals); B. Individual conducting the Trauma Assessment; C. School system representative with direct knowledge of the educational status of the child; D. Medical health provider with direct knowledge of the medical and dental status of the Foster Care Enrollee; E. Representative from the appropriate court system if the child had any court or law enforcement involvement including local law enforcement officials or a Court Appointed Special Advocate (CASA); F. A Behavioral Health representative with direct knowledge of the behavioral health or substance use issues affecting the child or family; G. Foster Parent(s) or Out of Home Placement provider where the child resided during the assessment process with direct knowledge of the child's behavior and activity during the assessment; and H. Any other individual having appropriate information directly related to the FC Enrollee's case. The AT meeting is coordinated and facilitated by the Care Coordinator.	
	*Care Coordinator - Humana (Assessment Team Facilitator)	Name: Phone:		
	PCP/Pediatrician	Name: Phone:		
	Legal Custodian	Name: Phone:		

	DCBS Caseworker	Name: Phone:		
	Individual conducting Trauma Assessment	Name: Phone:		
	School Representative	Name: Phone:		
	Medical Health Provider 1	Name: Phone:		
	Medical Health Provider 2	Name: Phone:		
	Court System Representative or CASA	Name: Phone:		
	Behavioral Health Provider 1	Name: Phone:		
	Behavioral Health Provider 2	Name:		
	Foster Parent(s)	Name: Phone:		
	Out-of-Home Placement Provider where child resided	Name: Phone:		
	Other, specify Role	Name: Phone: Role:		
	Other, specify Role	Name: Phone: Role:		
	Other, specify Role	Name: Phone: Role:		
	Other, specify Role	Name: Phone: Role:		
28 - a	Additional Notes/Assessment Team members:			
28 - b	If you have a DCBS caseworker, what is the reason?	Legal Children Services Community Safety Issues Domestic Violence Mental Health (parents/caregivers) Drugs / Alcohol abuse in the home None Other: _____ Details: _____	If child welfare agency caseworker is identified, inquire about environmental and safety concerns	
28 - c	Date input received from assigned DCBS case worker:	Date:		
	Nutrition and Development			
29	*Does your child have any special dietary needs?	Yes No Details: _____		
30	*Are there concerns about your child's weight? Do you have concerns about feeding, chewing and/or swallowing?	Details:		
31	*Compared to other children your child's age, would you say his/her health is…..?	Excellent Very Good Good Fair Poor		
32	*Is there any activity that your child is unable to do that other children his/her age can do?	Details:		
33	*Do you have any concerns about your child's memory or ability to learn at the same pace as their peers? If Yes, refer to Assessment Team for cognition and developmental assessment/screening referral	Yes No Details: _____		

34	*What type of school does your child attend?	Does not yet attend school Public Public school with Special Needs Classroom Country DD school Charter Home school Community school Preschool / Head Start Preschool - Special Needs Attends daycare Is age-appropriate but not currently attending school Other: _____ Details:	Probe safe supervision/ child's safety at school/daycare; injuries, etc.	
35	*Do you worry about your child's progress in school?	Yes No N/A Notes:	If yes: - System for tracking med? - Caregiver/ or informal supports? - MD appointment - School supports	
36	*Is your child on an Individualized Education Plan?	Yes No N/A Notes:	If Yes: - Probe whether IEP is functioning well for the child - Probe if problems in reading level, difficulties with learning, hearing, vision, etc.	
37	*Does your child display or is your child impacted by any of the following?	Display of aggression / bullying behavior Victim of bullying Victim of traumatic incident Witness to violence in home or community History of abuse, neglect, abandonment None reported Details: _____		
38	*Has your child visited the Emergency Room in the past 6 months? If yes, how many visits? Reason for visit:	Yes No Notes:	If yes: - Probe on whether member was admitted - Determine if urgent care center information is available to member and warm transfer to member services as needed.	
39	*Has your child visited an urgent care in the past 6 month? If yes, how many visits? Reason for visit?	Yes No Notes:		
40	*Has your child stayed overnight in the hospital in the past 6 months? If yes, how many visits? Reason for visit:	Yes No Notes:	If yes: Probe on admission dx Determine whether member understands S/S red flags (use clinical guideposts as appropriate) Verify that member is seeking ongoing ambulatory care with most important provider(s)	
41	*What is your child's current living situation?	Homeless Lives in with a foster family Lives in a group home Lives in residential treatment facility Lives in a shelter Lives with biological family unit Lives with adoptive family unit Lives in kinship care Lives with fictive kin Lives in an out-of-state facility In a Nursing facility Other: _____ Details:	If unstable environment is identified, probe on safety and immediate needs. Opportunity to identify caregiver status/ and/or informal supports as appropriate.	
44	*Are there any safety concerns in your home/current residence?	Yes None reported Details: _____		
45	If child is in foster care, do you have the child's medical passport and is it up to date?	Yes No Details: _____	If the answer is No, follow up to help track it down, replace it, or update the passport as needed.	
46	*Do you and/or your child have a child welfare agency caseworker? If yes, what is the reason you have a caseworker?	Legal Children Services Community Safety Issues Domestic Violence Mental Health (parents/caregivers) Drugs / Alcohol abuse in the home None Other: _____ Details:	If child welfare agency caseworker is identified, inquire about environmental and safety concerns	
	Behavioral Health (PHQ2 / PHQ9)			

47	*Over the last 2 weeks, how often has your child had little interest or pleasure in doing things?	Not at all = 0 points Several days = 1 point More than half the days = 2 points Nearly every day = 3 points	Validate response - are there any grade changes, school changes, or home changes that could affect mood or mental status	
48	*Over the last 2 weeks, how often has your	Not at all = 0 points	Validate response - are there any grade changes, school changes, or	
49	*Is the PHQ2 score 4 or more? If yes, continue to next question. If No, skip to 54	Yes No		
50	Over the last 2 weeks, how often has your child had trouble falling/staying asleep, or is sleeping too much?	Not at all = 0 points Several days = 1 point More than half the days = 2 points Nearly every day = 3 points		
51	Over the last 2 weeks, how often has your child been feeling tired or having little energy?	Not at all = 0 points Several days = 1 point More than half the days = 2 points Nearly every day = 3 points		
52	Over the last 2 weeks, how often has your child had poor appetite or overeating?	Not at all = 0 points Several days = 1 point More than half the days = 2 points Nearly every day = 3 points		
53	Over the last 2 weeks, how often has your child been feeling bad about themselves or that they are a failure or have let themselves or the family down?	Not at all = 0 points Several days = 1 point More than half the days = 2 points Nearly every day = 3 points		
54	Over the last 2 weeks, how often has your child had trouble concentrating on things, such as reading the newspaper or watching television?	Not at all = 0 points Several days = 1 point More than half the days = 2 points Nearly every day = 3 points		
55	Over the last 2 weeks, how often has your child been moving or speaking so slowly that other people could have noticed? Or, the opposite; being so fidgety or restless that they have been moving around a lot more than usual?	Not at all = 0 points Several days = 1 point More than half the days = 2 points Nearly every day = 3 points		
56	Over the last 2 weeks, how often has your child had thoughts that they would be better off dead or hurting themselves in some way?	Not at all = 0 points Several days = 1 point More than half the days = 2 points Nearly every day = 3 points		
57	Static Text: Add all 9 PHQ questions to calculate total score. Score of 5-14 indicates moderate depression and member should follow up with their physician to discuss treatment options based on the duration of symptoms and functional impairment. If RN CM, consider consultation with Medicaid BH CM if further support is required for the member. Score of 15-27 indicates severe depression and treatment with a combination of therapy and medication recommended. Ensure treatment options for behavioral health provider are given and include Medicaid BH CM in MDT discussion. If member is suicidal, follow process for	What is the total PHQ9 Score and recommended action?:		
58	*In the past, has your child ever thought about or attempted to harm him/herself?	Yes No Details: _____	1. Keep the member SAFE by keeping them on the phone 2. Verbalize your desire to assist the member 3. Signal to co-worker for help without going on hold 4. Employ immediate assistance from a first responder (911 etc.) 5. Follow the Crisis Policy	
59	*Does your child currently have any thoughts about harming his/herself? Have they talked about a plan?	Yes No Details: _____	1. Keep the member SAFE by keeping them on the phone 2. Verbalize your desire to assist the member 3. Signal to co-worker for help without going on hold 4. Employ immediate assistance from a first responder (911 etc.) 5. Follow the Crisis Policy	
60	*Any other areas of concern related to your child's health? Is there anything that I did not ask you that you would like me to know?	Details:	This question allows for CM willingness to change as well as self-determination.	
61	*Does your child (the member) drink alcohol or use drugs/substances? If Yes is answered, promptly complete the CRAFFT survey after this assessment is completed.	Yes No Don't know N/A		
62	*Has he/she received treatment for alcohol or substance use?	Yes No N/A		

63	*Has the child experienced physical or sexual abuse, neglect, or been exposed to violent behavior?	Yes No Don't know/None reported Details: _____		
64	*Does he/she exhibit unusual or uncontrollable behavior?	Yes No Don't know Details:		
65	*Has he/she been sent to Juvenile Detention or Jail? (For children 10 years or older)	Yes No N/A - child under 10 years of age Details: _____		
66	*Behavioral Health Section Comments			
	Personal Goal			
67	*Goal Name/Details:			
68	*Priority:			
69	*Enrollee Strengths:	Member's family/support system is highly involved in member's care Member is involved in the community Other: _____		
70	*Barriers:	Caregiver Assistance (lack of resources) Cognition difficulty/Confusion Dexterity issues Financial issues Inappropriate behaviors and/or psychosis Mobility issues Sensory deficits Transportation issues Other:		
71	*Member Preferences:			
72	*Interventions:	Caregiver assistance Community resource coordination Facility assistance Family assistance HHA Reminders Other:		
73	*Goal Notes:			
	Medical Goal			
74	*Goal Name/Details:			
75	*Priority:			
76	*Enrollee Strengths:	Member's family/support system is highly involved in member's care Member is involved in the community Other: _____		
77	*Barriers:	Caregiver Assistance (lack of resources) Cognition difficulty/Confusion Dexterity issues Financial issues Inappropriate behaviors and/or psychosis Mobility issues Sensory deficits Transportation issues Other:		
78	*Member Preferences:			

79	*Interventions:	Caregiver assistance Community resource coordination Facility assistance Family assistance HHA Reminders Other:		
80	*Goal Notes:			
	Follow Up Plan			
81	*At a minimum, what will the frequency of contact be with this member?	Monthly Quarterly Every 6 months Annual		
82	*What is the member's preferred method of contact?	Face to Face Phone Other: _____		
83	*Follow Up Due on or by:	Date:		

Other: _____

Details: _____

Other: _____

Details: _____