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Member Name: Responder's Name: Member Healthcare ID: DOB: State:	Cell Phone: ( ) Other: ( ) DATE: / /

#	QUESTION (*Indicates Mandatory)	RESPONSE
	*Person completing this assessment:	☐Adoptive Parent ☐Biological Parent ☐DCBS Worker ☐Foster Parent ☐Non-Relative Caregiver ☐Relative Caregiver ☐Other _____
	*Date of Needs Assessment completion:	/ /
	*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 ☐Mailed ☐In-person ☐Portal

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	*Assessment Type:	☐Initial ☐Monthly Update ☐Quarterly Update ☐Annual ☐Caregiver ☐Environment ☐Health ☐Income ☐Living Situation ☐Significant Change in Condition ☐Member Representative Request
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: _____
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: _____
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: _____
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?	Detail:

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5	*Does your child have any of these diagnoses/conditions?	☐ ADHD ☐ Asthma ☐ Autism ☐ 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 ☐ Heart Failure ☐ ESRD / Kidney disease / Dialysis ☐ Hepatitis ☐ HIV / AIDS ☐ Liver Disease ☐ Multiple Sclerosis (MS) ☐ NICU graduate ☐ Muscular Dystrophy (MD) ☐ Respiratory with oxygen ☐ Paraplegia / Quadriplegia ☐ Sickle Cell disease ☐ Spina Bifida / Neural tube defect ☐ Teen Pregnancy ☐ Tuberculosis ☐ Intellectual / Developmental Disabilities ☐ Behavioral Health Conditions: ☐ Anxiety ☐ Bipolar Disorder ☐ Depression ☐ Eating Disorder ☐ Psychotic Disorders (Schizophrenia) ☐ Substance Use Disorders (SUD) ☐ None ☐ Other: _____
6	*Do you receive help at home caring for your child because of his/her health problems?	☐ Yes ☐ No ☐ N/A Details: _____

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7	Are you receiving the help that you need?	☐ Yes ☐ No ☐ N/A ☐ Details: _____
8	*What service(s) is your child receiving?	☐ Area Agency on Aging (AAA) ☐ Behavioral Health Services ☐ Chemotherapy ☐ Developmental Therapy ☐ Dialysis ☐ Home Health Agency Services ☐ DME ☐ Hospice ☐ Medical Care ☐ Occupational Therapy ☐ Physical Therapy ☐ PPEC ☐ Private Duty Nursing ☐ Prosthetic Fitting ☐ Radiation Therapy ☐ Special Education Services ☐ Rehabilitative ☐ Speech Therapy ☐ Substance Abuse ☐ 24-hour supports from a Medicaid Waiver Provider ☐ None ☐ Other: _____
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 ☐ Other: _____

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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: _____ Details: _____

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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: _____ Details: _____
15	*What kinds of care do you have problems accessing? For example, getting an appointment to see your PCP.	☐PCP appointments ☐Specialty appointments ☐HHC access ☐Dental care ☐Behavioral Health care ☐Therapies (PT, OT, ST) ☐Access to a Pharmacy ☐Access to a vision provider ☐None ☐Other: _____ Details: _____
16	*There are many things that can cause stress to you or your family or impact your health. Do you have any concerns with:	☐Feeling safe in your home ☐Discrimination ☐Tax Issues ☐Immigration ☐Falling Easily based on Health ☐Bankruptcy Crime in your neighborhood ☐Navigational barriers in the home (multi-level) ☐Home layout or Physical hazards in the home (clutter, electrical wiring) ☐Divorce/custody/guardianship ☐Eviction/Housing issues with landlord ☐None ☐Other: _____ Details: _____

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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 for Well Child Exams?	☐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: _____ 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

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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: _____
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: _____
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: _____
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

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		Details: _____
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: _____
Nutrition and Development		
28	*Does your child have any special dietary needs?	☐Yes ☐No Details: _____
29	*Are there concerns about your child's weight? Do you have concerns about feeding, chewing and/or swallowing?	☐Yes ☐No Details: _____
30	*Compared to other children your child's age, would you say his/her health is…..?	☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor
31	*Is there any activity that your child is unable to do that other children his/her age can do?	Details:

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32	*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: _____
33	*What type of school does your child attend?	☐Public ☐Charter ☐Community school ☐Attends daycare ☐Country DD school ☐Home school ☐Preschool / Head Start ☐Preschool - Special Needs ☐Public school with Special Needs Classroom ☐Does not yet attend school ☐Is age-appropriate but not currently attending school ☐Other: _____ Details: _____
34	*Do you worry about your child's progress in school?	☐Yes ☐No ☐N/A Notes:
35	*Is your child on an Individualized Education Plan?	☐Yes ☐No ☐N/A Notes:

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36	*Does your child display or is your child impacted by any of the following?	☐ Victim of bullying ☐ Victim of traumatic incident ☐ Display of aggression/bullying behavior ☐ Witness to violence in home or community ☐ History of abuse, neglect, abandonment ☐ None reported Details: _____
37	*Has your child visited the Emergency Room in the past 6 months? If yes, how many visits? Reason for visit:	☐ Yes ☐ No Notes:
38	*Has your child visited an urgent care in the past 6 month? If yes, how many visits? Reason for visit?	☐ Yes ☐ No Notes:
39	*Has your child stayed overnight in the hospital in the past 6 months? If yes, how many visits? Reason for visit:	☐ Yes ☐ No Notes:
40	*What is your child's current living situation?	☐ Homeless ☐ Lives in a group home ☐ Lives in a shelter ☐ Lives with adoptive family unit ☐ Lives with fictive kin ☐ In a Nursing facility ☐ Lives in with a foster family ☐ Lives in residential treatment facility ☐ Lives with biological family unit ☐ Lives in kinship care ☐ Lives in an out-of-state facility ☐ Other: _____ Details: _____

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41	*Are there any safety concerns in your home/current residence?	☐Yes ☐None reported Details: _____
42	If child is in foster care, do you have the child's medical passport and is it up to date?	☐Yes ☐No Details: _____
43	*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: _____
	Behavioral Health/Substance Use	
44	*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
45	*Over the last 2 weeks, how often has your child been feeling down, depressed or hopeless?	☐Not at all = 0 points ☐Several days = 1 point ☐More than half the days = 2 points ☐Nearly every day = 3 points
46	*Is the PHQ2 score 4 or more?	☐Yes ☐No If yes, continue to next question. If No, skip to 55.

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47	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
48	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
49	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
50	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
51	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
52	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
53	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

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54	Static Text: Add all 9 PHQ questions (#44, 45, 47-53) 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 imminent risk.	What is the total PHQ9 Score and recommended action?
55	*In the past, has your child ever thought about or attempted to harm him/herself?	☐Yes ☐No Details: _____
56	*Does your child currently have any thoughts about harming his/herself? Have they talked about a plan?	☐Yes ☐No Details: _____
57	*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:
58	*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

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59	*Has he/she received treatment for alcohol or substance use?	☐Yes ☐No ☐N/A
60	*Has the child experienced physical or sexual abuse, neglect, or been exposed to violent behavior?	☐Yes ☐No ☐Don't know/None reported Details: _____
61	*Does he/she exhibit unusual or uncontrollable behavior?	☐Yes ☐No ☐Don't know Details: _____
62	*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: _____
63	*Behavioral Health Section Comments	Details:
	Personal Goal	
64	*Goal Name/Details:	Details:
65	*Priority:	Details:

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66	*Enrollee Strengths:	☐ Member's family/support system is highly involved in member's care ☐ Member is involved in the community ☐ Other: _____
67	*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: _____
68	*Member Preferences:	Details:
69	*Interventions:	☐ Caregiver assistance ☐ Community resource coordination ☐ Facility assistance ☐ Family assistance ☐ HHA ☐ Reminders ☐ Other: _____
70	*Goal Notes:	Details:
	Medical Goal	
71	*Goal Name/Details:	Details:
72	*Priority:	Details:

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73	*Enrollee Strengths:	☐ Member's family/support system is highly involved in member's care ☐ Member is involved in the community ☐ Other: _____
74	*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: _____
75	*Member Preferences:	Details:
76	*Interventions:	☐ Caregiver assistance ☐ Community resource coordination ☐ Facility assistance ☐ Family assistance ☐ HHA ☐ Reminders ☐ Other: _____
77	*Goal Notes:	Details:
Assessment Team Participants		
78	List all individuals including full Name, Phone #, and Title/Role if not already specified.	
	*Care Coordinator - Humana (Assessment Team Facilitator)	Name: Phone:
	PCP/Pediatrician	Name: Phone:
	Legal Custodian	Name: Phone:

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	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: Phone:
	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:

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78 - a	Additional Notes/Assessment Team members:	
78 - 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: _____
78 - c	Date input received from assigned DCBS case worker:	Date:
	Follow Up Plan	
79	*At a minimum, what will the frequency of contact be with this member?	☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Annual
80	*What is the member's preferred method of contact?	☐ Face to Face ☐ Phone ☐ Other: _____
81	*Follow Up Due on or by:	Date: