Draft

PASSPORT HEALTH PLAN

Medicaid - Initial Pediatrics - Passport Assessment for Member Name (Member ID)

Q1	The Initial Pediatrics call is being completed with:
	Member
	Spouse/Partner
	Parent/Legal Guardian
	Other Caregiver
	Other Member Representative (e.g., Adult Child/Sister/Brother/Siblings)
	Power of Attorney - Healthcare
	Declined to Answer
	Other

Q2	What type of assessment is being completed?
	Newborn Assessment (Detained Baby > 7 Days & < 34 Weeks) 2400
	Pediatric Assessment
	NA per LOB Policy

Q3	What is the primary language spoken?
	Arabic
	Bosnian
	Burmese
	Cambodian
	Chinese
	English
	French
	German
	Russian
	Sign Language
	Somali
	Spanish
	Sudanese
	Vietnamese
	Declined to Answer
	Other

Q4	Does the member speak the English language?
	Yes
	No

Q5	If no, does anyone in the house speak English?
	Yes
	No

Q6	Can the member read the English language?
	Yes
	No
	Declined to Answer

Q7	Can anyone in the household or a friend/family member read English?
	Yes (Please Describe Below in the COMMENTS Box)
	No
	Declined to Answer

Q8	Is the member/caregiver willing to participate in the CM program?
	Yes
	No

Q9	Does the member/parent/guardian give the CM permission to speak to another caregiver?
	Yes
	Consent Form Sent (Per LOB Policy)
	No
	N/A

Q10	Who is the Primary Caregiver?
	Mother
	Father
	Grandparent
	Foster Family
	Legal Guardian
	No One
	Other

Q11	Who else provides care to the member?
	Mother
	Father
	Grandparent
	Foster Family
	Legal Guardian
	No One
	Other

Q12	Does the member have or need assistance with caregiving?
	Yes (Please Describe Below in the COMMENTS Box)
	No
	Declined to Answer

Q13	If yes, please indicate the level of involvement:
	Yes - Caregiver Currently Provides Assistance
	Yes - Caregiver Needs Training, Supportive Service
	Caregiver is Not Likely to Provide Assistance
	Unclear if Caregiver Will Provide Assistance
	Assistance Needed but No Caregiver Available

Q14	Which of these Behavioral/Mental Health condition(s) is/are the member's primary health concern(s)?
	None
	ADHD/ADD
	Anxiety
	Autism Spectrum Disorder
	Bipolar Disorder
	Conduct Disorder
	Depression
	Drug Overdose
	Eating Disorder
	Intellectual Disability
	Intermittent Explosive Disorder
	Mood Disorder - Disruptive Mood Dysregulation Disorder
	Oppositional Defiant Disorder
	Panic Disorder
	Personality Disorder
	Post Traumatic Stress Disorder
	Psychotic Disorder
	Schizophrenia
	Substance Use Disorder
	Suicidal Ideation/Attempt
	Other

Q15	Which of these Brain/Nervous System condition(s) is/are the member's primary health concern(s)?
	None
	Cerebral Palsy
	Encephalopathy/Micro Encephalopathy
	Fetal Alcohol Syndrome
	Hydrocephalus
	Intraventricular Hemorrhage
	Seizure Disorder
	Spina Bifida
	Traumatic Brain Injury
	Other

Q16	Does the member have Cancer as a primary health concern?
	Yes (Please Describe Below in the COMMENTS Box)
	No

Q17	Which of these Circulatory System condition(s) is/are the member's primary health concern(s)?
	None
	CVA/Stroke
	Cardiac Malformations
	Heart Failure
	Hemophilia
	HTN
	Hyperlipidemia
	Sickle Cell Disease
	Other

Q18	Which of these Congenital Anomalies/Genetic Disorders is/are the member's primary health concern(s)?
	None
	Cleft Palate
	Cleft Lip
	Downs Syndrome
	Other

Q19	Which of these Endocrine System condition(s) is/are the member's primary health concern(s)?
	None
	Diabetes
	Metabolic Syndrome
	Obesity
	Other

Q20	Which of these Environmental Issues is/are the member's primary health concern(s)?
	None
	Accidental Overdose
	Hyperthermia
	Hypothermia
	Lead Poisoning
	Other

Q21	Which of these Gastroenterology condition(s) is/are the member's primary health concern (s)?
	None
	Accidental Overdose/Poisoning
	Celiac Disease
	Cirrhosis
	Crohn's Disease
	GERD
	Liver Failure
	Necrotizing Enterocolitis
	Pyloric Stenosis
	Short Gut Syndrome
	Other

Q22	Which of these Nutrition/Feeding Difficulty condition(s) is/are the member's primary health concern(s)?
	None
	Dysphagia
	Esophageal Narrowing
	Failure to Thrive
	Other

Q23	Which of these Ophthalmology condition(s) is/are the member's primary health concern (s)?
	None
	Cataracts
	Retinopathy
	Other

Q24	Which of these Immune System condition(s) is/are the member's primary health concern (s)?
	None
	Hepatitis
	HIV/AIDS
	Infectious Disease
	Juvenile Rheumatoid Arthritis
	Other

Q25	Which of these Integumentary System condition(s) is/are the member's primary health concern(s)?
	None
	Burns
	Eczema
	Wounds
	Other

Q26	Which of these Muscular System condition(s) is/are the member's primary health concern (s)?
	None
	Muscular Dystrophy
	Para/Quadriplegia
	Other

Q27	Does the member have Prematurity as a primary health concern?
	Yes (Please Describe Below in the COMMENTS Box)
	No

Q28	Which of these Reproductive System condition(s) is/are the member's primary health concern(s)?
	None
	Onset of Menses
	Polycystic Ovary Syndrome
	Precocious Puberty
	Pregnancy
	Other

Q29	Which of these Respiratory System condition(s) is/are the member's primary health concern(s)?
	None
	Asthma
	Bronchitis
	Chronic Lung Disease
	Cystic Fibrosis
	Pneumonia
	RAD (Reactive Airway Disease)
	Respiratory Failure
	RSV (Respiratory Syncytial Virus)
	Subglottic Stenosis
	Other

Q30	Which of these Skeletal System condition(s) is/are the member's primary health concern (s)?
	None
	Amputation
	Fractures
	Scoliosis
	Other

Q31	Which of these Urinary System condition(s) is/are the member's primary health concern (s)?
	None
	Kidney Failure
	Kidney Stone
	Neurogenic Bladder
	Other

Q32	What are the member's past Behavioral/Mental Health condition(s)?
	None
	ADHD/ADD
	Anxiety
	Autism Spectrum Disorder
	Bipolar Disorder
	Conduct Disorder
	Depression
	Drug Overdose
	Eating Disorder
	Intellectual Disability
	Intermittent Explosive Disorder
	Mood Disorder - Disruptive Mood Dysregulation Disorder
	Oppositional Defiant Disorder
	Panic Disorder
	Personality Disorder
	Post Traumatic Stress Disorder
	Psychotic Disorder
	Schizophrenia
	Substance Use Disorder
	Suicidal Ideation/Attempt
	Other

Q33	What are the member's past Brain/Nervous System condition(s)?
	None
	Cerebral Palsy
	Encephalopathy/Micro Encephalopathy
	Fetal Alcohol Syndrome
	Hydrocephalus
	Intraventricular Hemorrhage
	Seizure Disorder
	Spina Bifida
	Traumatic Brain Injury
	Other

Q34	Has the member had Cancer as a past health condition?
	Yes (Please Describe Below in the COMMENTS Box)
	No

Q35	What are the member's past Circulatory System condition(s)?
	None
	CVA/Stroke
	Cardiac Malformations
	Heart Failure
	Hemophilia
	HTN
	Hyperlipidemia
	Sickle Cell Disease
	Other

Q36	What are the member's past Congenital Anomalies/Genetic Disorders?
	None
	Cleft Palate
	Cleft Lip
	Downs Syndrome
	Other

Q37	What are the member's past Endocrine System condition(s)?
	None
	Diabetes
	Metabolic Syndrome
	Obesity
	Other

Q38	What are the member's past Environmental Issue condition(s)?
	None
	Accidental Overdose
	Hyperthermia
	Hypothermia
	Lead Poisoning
	Other

Q39	What are the member's past Gastroenterology condition(s)?
	None
	Accidental Overdose/Poisoning
	Celiac Disease
	Cirrhosis
	Crohn's Disease
	GERD
	Liver Failure
	Necrotizing Enterocolitis
	Pyloric Stenosis
	Short Gut Syndrome
	Other

Q40	What are the member's past Nutrition/Feeding Difficulty condition(s)?
	None
	Dysphagia
	Esophageal Narrowing
	Failure to Thrive
	Other

Q41	What are the member's past Ophthalmology condition(s)?
	None
	Cataracts
	Retinopathy
	Other

Q42	What are the member's past Immune System condition(s)?
	None
	Hepatitis
	HIV/AIDS
	Infectious Disease
	Juvenile Rheumatoid Arthritis
	Other

Q43	What are the member's past Integumentary System condition(s)?
	None
	Burns
	Eczema
	Wounds
	Other

Q44	What are the member's past Muscular System condition(s)?
	None
	Muscular Dystrophy
	Para/Quadriplegia
	Other

Q45	Has the member had Prematurity as a past health condition?
	Yes (Please Describe Below in the COMMENTS Box)
	No

Q46	What are the member's past Reproductive System condition(s)?
	None
	Onset of Menses
	Polycystic Ovary Syndrome
	Precocious Puberty
	Pregnancy
	Other

Q47	What are the member's past Respiratory System condition(s)?
	None
	Asthma
	Bronchitis
	Chronic Lung Disease
	Cystic Fibrosis
	Pneumonia
	RAD (Reactive Airway Disease)
	Respiratory Failure
	RSV (Respiratory Syncytial Virus)
	Subglottic Stenosis
	Other

Q48	What are the member's past Skeletal System condition(s)?
	None
	Amputation
	Fractures
	Scoliosis
	Other

Q49	What are the member's past Urinary System condition(s)?
	None
	Kidney Failure
	Kidney Stone
	Neurogenic Bladder
	Other

Q50	Has the member had any Cancer-related surgeries?
	Yes (Please Describe Below in the COMMENTS Box)
	No

Q51	What Cardiac surgeries has the member had?
	None
	Atrial Septal Defect
	Coarctation of the Aorta
	Hypoplastic Left Heart Syndrome
	Patent Ductus Arteriosus
	Tetralogy of Fallout
	Ventricular Septal Defect
	Other

Q52	What ENT surgeries has the member had?
	None
	Adenoid
	Ear Tubes - Pressure Equalization (PE)
	Tonsillectomy
	Tracheostomy
	Other

Q53	What Gastroenterology surgeries has the member had?
	None
	Appendectomy
	Cholecystectomy
	Cleft Lip Repair
	Cleft Palate Repair
	Feeding Tube
	Feeding Tube with Nissen
	Ostomy
	Other

Q54	What Genitourinary surgeries has the member had?
	None
	Hydrocele Repair
	Hypospadias Repair
	Undescended Testicle Repair
	Other

Q55	What Hernia Repair surgeries has the member had?
	None
	Diaphragmatic
	Inguinal
	Umbilical
	Other

Q56	What Integumentary surgeries has the member had?
	None
	Debridement of Wound
	Skin Graft
	Other

Q57	What Neurology surgeries has the member had?
	None
	Brain Decompression Bolts
	Brain Surgery for Seizure(s)
	Shunt Placement/Revision
	Surgery for Traumatic Brain Injury
	Other

Q58	What Orthopedic surgeries has the member had?
	None
	Club Foot Repair
	Congenital Dislocation of Hips
	Spinal Deformities
	Other

Q59	What procedures has the member had?
	None
	Biopsy
	Excision
	PICC Line Placement/Removal
	Port Placement/Removal
	Shunt Placement/Removal
	Other

Q60	What Transplant surgeries has the member had?
	None
	Bone Marrow
	Heart
	Intestinal
	Kidney
	Liver
	Lung
	Other

Q61	Has the member had any other surgeries?
	Yes (Please Describe Below in the COMMENTS Box)
	No

Q62	Has the member missed work, school or had to limit daily activities because of his/her condition(s)?
	Yes (Please Describe Below in the COMMENTS Box)
	No
	Declined to Answer

Q63	What past treatments has the member received? Please document when treatment was received under each selected item.
	None
	Behavioral Health Services
	Substance Abuse Treatment
	Cardiac Rehab
	Dietary Restrictions
	Disease Education
	DME
	Home Health Care
	Medication Management
	Occupational Therapy
	Oxygen
	Physical Therapy
	School Services
	Smoking Cessation
	Speech Therapy
	Wound Care
	Declined to Answer
	Other

Q64	What current treatments does the member receive? Please document when treatment began and expected length of time under each selected item.
	None
	Behavioral Health Services
	Substance Abuse Treatment
	Cardiac Rehab
	Dietary Restrictions
	Disease Education
	DME
	Home Health Care
	Medication Management
	Occupational Therapy
	Oxygen
	Physical Therapy
	School Services
	Smoking Cessation
	Speech Therapy
	Wound Care
	Declined to Answer
	Other

Q65	Has the member been admitted to the hospital in the past 6 months? If yes, please list dates and reasons.
	Yes (Please Describe Below in the COMMENTS Box)
	No
	Unknown
	Declined to Answer

Q66	Has the member utilized the emergency department in the past 6 months? If yes, please list dates and reasons.
	Yes (Please Describe Below in the COMMENTS Box)
	No
	Unknown
	Declined to Answer

Q67	Is the member a candidate for Synagis (RSV)?
	Yes
	No
	N/A

Q68	If yes, has the member received a Synagis injection?
	Yes
	No
	N/A

Q69	If yes, list the dates received and next scheduled date, if applicable
	No Response

Q70	I would like to review the member's medications, including over the counter meds and samples. I want to make sure they match our records. (Only document the meds that are different than the listed meds per system by member/caregiver.)
	No Response

Q71	Which of the following do you have an allergy to?
	Food
	Medication
	Insects
	Animals
	Trees
	Grass
	Pollution
	Dust
	Other
	None
	Declined to Answer

Q72	If yes, what is/are the member's reactions to the allergen(s)?
	Breathing Difficulties
	Hives
	Itching
	Rash
	Tongue Swells
	Other
	Unknown
	Declined to Answer
	N/A

Q73	Discuss member's immunizations records. Check Care Gap information.
	No Response

Q74	How often does the member see his/her primary medical provider?
	Weekly
	Twice a Month
	Monthly
	Every Two Months
	Every Three Months
	Every Six Months
	Yearly
	As Needed
	Other

Q75	Has the member's next PCP appointment been scheduled?
	Yes
	No, Not Scheduled
	Unknown
	Other
	N/A

Q76	If yes, what is the date of the member's next PCP appointment?
	No Response

Q77	Which of the following specialists does the member receive care from?
	Adolescent
	Allergist
	Audiologist
	Cardiologist
	Dentist/Oral Surgeon
	Dermatologist
	Developmental Pediatrician
	Endocrinologist
	ENT
	Gastroenterologist
	Geneticist
	OB/GYN
	Hematologist/Oncologist
	Infectious Disease
	Neonatologist
	Nephrologist
	Neurologist
	Nutrition/Weight Management
	Ophthalmologist
	Orthopedic
	Pain Management
	Perinatologist

	Psychiatrist
	Podiatrist
	Pulmonologist
	Rheumatologist
	Surgeon
	Therapist
	Urologist
	Wound Care
	Other
	None

Q78	Does the member's caregiver feel the PCP and/or specialist(s) have communicated an overall treatment plan in a manner the caregiver understands?
	Yes (Please Describe Below in the COMMENTS Box)
	No (Please Describe Below in the COMMENTS Box)

Q79	Does the caregiver agree/follow the treatment plan?
	Yes (Please Describe Below in the COMMENTS Box)
	No (Please Describe Below in the COMMENTS Box)

Q80	Has the member been seen by any dental provider in the last six months?
	Yes
	No
	Unknown

Q81	Please provide the member's most current height:
	No Response

Q82	Please provide the member's most current weight:
	No Response

Q83	Please provide the member's BMI classification:
	BMI <5th Percentile (Underweight)
	BMI 5th-84th Percentile (Healthy Weight)
	BMI 85th-94th Percentile (Overweight)
	BMI > or Equal to 95th Percentile (Obese)

Q84	How does the member receive nutrition? Select all that apply and specify formula or special diet.
	Mouth/Regular
	Mouth/Soft
	Mouth/Pureed
	Mouth/Liquid
	Breast/Bottle
	NG or NJ Tube
	GT or JT
	TPN
	Combination

Q85	What medical equipment is in the home?
	BiPAP
	Braces or Splints
	Car Seat
	Coffalator
	Commode
	Communication Equipment
	CPAP
	Dressing Supplies
	Glasses
	Glucometer
	GT Tube Supplies
	Helmet
	Incontinent Supplies
	Lift
	Monitors - Heart, Resp, Apnea, Glucose
	Nebulizer
	Ostomy Supplies
	Oxygen
	Percussion Vest
	Potty Seat
	Power Wheelchair
	Pulse Oximeter

	Seating for Feeding/Activities
	Spacer
	Special Cribs or Beds
	Stander
	Stroller
	Suction
	Toileting
	Tracheotomy Supplies
	Ventilator
	Walker
	Weighted Blanket
	Weighted Vest
	Wheelchair
	Other

Q86	Based on assessment, is there additional equipment which might benefit the member?
	Yes
	No

Q87	What is the member's current living arrangement?
	With Parent(s) or Guardian(s)
	Sibling(s)
	With Other Relative(s)
	With Non-Relative(s)
	Homeless
	Shelter
	Group Home
	Residential Treatment
	Facility
	Other
	Declined to Answer

Q88	Does the member have siblings that live in the household?
	Yes
	No
	Declined to Answer

Q89	If yes, provide age(s) and list any disabilities/special needs, medical condition(s) and/or behavioral health condition(s).
	No Response

Q90	Where does the member sleep?
	Bassinet
	Crib
	Co-Sleeping
	Own Bed
	Declined to Answer
	Other

Q91	Does the member have any problems accessing the home?
	Yes (Please Describe Below in the COMMENTS Box)
	No
	Declined to Answer

Q92	If the member has any problems accessing the home please select all that apply.
	Difficulty with Entering or Leaving the House
	Difficulty with Navigating in the House
	Stairs Make it Difficult or Impossible to Leave the House
	In Wheelchair with No Ramp or Elevator
	Difficulty with Transfer
	Too Weak to Leave the House
	Other
	No Difficulty

Q93	Do you feel safe in your present environment?
	Yes
	No (Please Describe Below in the COMMENTS Box)
	Declined to Answer

Q94	Was there a time in your past when you did not feel safe in your environment?
	Yes (Please Describe Below in the COMMENTS Box)
	No
	Declined to Answer

Q95	Does the member use or has the member ever used any of the following?
	Use Street Drugs
	Methadone
	Suboxone
	Alcohol
	Overuse of Prescription Drugs
	Smoke Cigarettes
	Use of Other Tobacco Products
	Other
	N/A
	Declined to Answer

Q96	If the member drinks alcohol, how frequently?
	Rarely
	1-2 Drinks per Day
	3-4 Drinks per Day
	More Than 5 Drinks per Day
	Other
	Declined to Answer
	N/A

Q97	If the member smokes tobacco, how much each day?
	1 to 10 Cigarettes
	1 Pack
	1 to 2 Packs
	More than 2 Packs
	Other
	Declined to Answer
	N/A

Q98	Is the member exposed to second hand smoke?
	Yes (Please Describe Below in the COMMENTS Box)
	No
	Other
	Declined to Answer

Q99	Is member sexually active?
	Yes
	No
	Unsure
	Declined to Answer

Q100	Are there cultural traditions that you follow in your daily life?
	Yes
	No
	Declined to Answer

Q101	If yes, please select all that are affected as a result of these cultural traditions:
	Blood Transfuions/Blood Products
	Dietary Practices
	Examination by a Male/Femaile Practitioner
	Family Traditions
	Medications (e.g. Pork/Beef Insulin)
	Rx/Procedures Discouraged/Not Allowed
	Transportation by Male/Female Driver
	Other
	None

Q102	Does the member have problems with vision?
	Yes
	No
	Declined to Answer

Q103	If yes, select all that apply to the member's vision problems:
	Legally Blind
	Wears Glasses or Contacts - Corrective Lenses

Q104	Does the member have problems with hearing?
	Yes
	No
	Declined to Answer

Q105	If yes, select all that apply to the member's hearing problems:
	Deaf
	Partial Hearing Loss
	Wears Hearing Aids
	Uses TTY Service

Q106	Does the member have any self care deficits?
	Yes
	No
	Declined to Answer

Q107	If the member has self care deficits, please select all that apply.
	Ambulate Independently
	Bathe
	Dress Yourself
	Exercise at Least 20 Minutes at a Time
	Feed Yourself
	Groom Yourself
	Laundry
	Light Housekeeping
	Looking Up Phone Numbers
	Managing Money
	Prepare Meals
	Read in Your Preferred Language
	Shopping
	Toileting
	Using the Telephone

Q108	Do you know what benefits member has and how to use them?
	Yes
	No
	Declined to Answer

Q109	If no, explain the benefits member doesn't understand:
	24 Hour Nurse Line
	Language Line
	Medicaid Transportation
	Member Services
	Mental Health Services
	Primary Medical Provider
	Rapid Response Outreach Team
	Urgent Care
	Other

Q110	Does the member have any health care needs that are not a covered benefit? Please list needs and referrals, if indicated.
	Yes (Please Describe Below in the COMMENTS Box)
	No

Q111	Please select from the following any services that the member currently receives or for which the member requires information.
	Waiver Program
	Child Protective Services
	Cerebral Palsy Kids Center
	Mental Health Center
	First Steps
	Clothing Assistance
	Food Pantries
	Gym
	Heating Assistance
	Housing Assistance
	Interpreter Services
	Support Groups
	Section 8 Housing
	About Special Kids
	Healthy Family
	Food Stamp Program
	Temporary Cash Assistance
	Foster Care Agency
	Commission for Children with Special Needs
	Head Start
	Medical Day Care
	WIC

	None
	Other

Q112	What form of transportation does the member use for medical appointment/services?
	Ambulance
	Cab
	Public Transportation
	Medicaid Transportation
	Caregiver
	Family/Friends
	Self
	Walking
	No Reliable Means
	Other
	Declined to Answer

Q113	When the caregiver/member is given things to read about the member's health, do they have any problems reading them?
	No Problem
	Can't Read at All
	Unable to Read Some of the Words (Please Describe Below in the COMMENTS box)
	Can't See Well Enough to Read
	Not in Main/Preferred Language
	Difficulty Understanding Materials
	Don't Like to Read (Please Describe Below in the Comments Box)
	Other
	Declined to Answer

Q114	Based upon your assessment of the member/caregiver, what are the cognitive skills for daily decision making?
	Independent (Decisions Consistent, Reasonable and Safe)
	Modified Independent (Some Difficulty)
	Minimally Impaired (Needs Cues)
	Severely Impaired (Rarely Makes Decisions)
	Unable to Assess

Q115	What does the Care Manager see as the member's/caregiver's barriers to following the treatment and/or self-management plan?
	Communication Skills
	Cultural
	Difficulty Obtaining Medications
	Do Not Believe Participation Will Improve Health
	Don't Know What I Need
	Environmental
	Financial
	Geographic
	Hearing Impairment
	Lack of Caregiver Support
	Lack of DME Supplies
	Lack of Knowledge - Condition
	Lack of Knowledge - Diet
	Lack of Knowledge - Disease
	Lack of Knowledge - Medications
	Lack of Knowledge - Medications Benefits
	Lack of Knowledge - Transportation Benefits
	Lack of Knowledge - Transportation
	Lack of Knowledge - Physical Health Benefits
	Lack of Knowledge - Mental Health Benefits
	Lack of Physical Exercise
	Lack of Support from Family

	Language
	Lifestyle Choices
	No Available/Convenient Par Providers
	No Barriers Identified
	Overuse of Prescription Drugs
	Primary Providers - Communication with Office
	Primary Provider's Office Hours
	Psychological Impairment
	Psychosocial Factors
	Religious
	Specialist's Office Hours
	Use of Alcohol
	Use of Methadone
	Use of Street Drugs
	Use of Tobacco
	Vision Impaired
	Other

Q116	Has the member/caregiver completed wills, living wills, advance directives and/or health care powers of attorney?
	Yes
	No
	Declined to Answer

Q117	What are some areas you would like to work on and feel you could benefit from additional support?
	Behavioral Health Needs
	Improved Self-Management of Health Condition
	Care Coordination
	Caregiver Needs
	Diet/Nutrition
	Disease Knowledge
	DME
	Electricity Assistance
	Housing Assistance
	Legal Needs
	Medication Assistance
	Resources
	Smoking Cessation
	Transportation Assistance
	Waiver Assistance
	Weight Gain
	Weight Loss
	Other