Health Home CNY
Care Management Agency ______________________

Patient Name ______________________
Gender ______________________
Date of Birth ______________________
Medicaid ID ______________________
NYS ID ______________________
Home Phone ______________________
Cell Phone ______________________
Other phone ______________________
Primary address ______________________
Other address ______________________

IDENTIFIED RISK FACTORS

Please check all the risk factors that the member currently has at the time of enrollment and/or reassessment. These questions are not meant to be asked of the member, but identified via other records, third party sources and/or completing the Comprehensive Assessment.

1. **Health Home Eligibility Type** *
   Select AT LEAST one option.
   a. Two or More Chronic Conditions b. Serious Emotional Disturbance (SED)
   c. Complex Trauma d. HIV/AIDS

2. **List Conditions**
   Please answer if question 1 is answered with any of the following option(s): Two or More Chronic Conditions
   [ ]

3. **List Condition**
   Please answer if question 1 is answered with any of the following option(s): Serious Emotional Disturbance (SED)
   [ ]

4. **I acknowledge that I need to upload the SED verification into the member's Documents Section**
   Please answer if question 1 is answered with any of the following option(s): Serious Emotional Disturbance (SED)

   Select ONE option.
   a. Yes b. No

5. **Member has probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)**
   Select AT LEAST one option.

a. Use various Quality Flags in PSYCKES, such as "Preventable admissions for asthma" "Preventable admissions for Diabetes", etc.
b. Anyone with a HH+ flag in PSYCKES at the time of enrollment
c. Anyone with a POP flag in PSYCKES at the time of enrollment
d. Anyone with an H-code in EMedNY at the time of enrollment (eligible or enrolled)
e. Direct referral from an inpatient medical, psychiatric or detox admission
f. Direct referral from ER, with frequent admissions (could also be captured as a PSYCKES category)
g. Direct referral from APS, CPS, or preventative program
h. Direct referral from MCO or medical provider
i. Other

6. **If answer to Question #1 was "Other", indicate a description**
Please answer if question 5 is answered with any of the following option(s): Other

7. **Member has a lack of or inadequate social/family/housing support, or serious disruptions in family relationships; needs benefits; nutritional insufficiency**
Select AT LEAST one option.
a. Meeting one of the HUD definitions for homelessness (HUD 1,2 and 4 housing)
b. Lack of social supports as evidenced by fewer than 2 people identified as a support by the member or change in guardianship
c. The institutionalization or nursing home placement of primary support/guardian
d. Needs assistance applying for/accessing benefits such as SNAP, SSI, etc.
e. Unable to access food due to financial limitations or ability to shop or access food site, dietary restrictions, etc.
f. Violence in the home
g. Other

8. **If "other", indicate a description**
Please answer if question 7 is answered with any of the following option(s): Other

9. **Member has a lack of or inadequate connectivity with healthcare system**
Select AT LEAST one option.

a. Individual does not have healthcare connectivity or utilization, e.g. does not have a PCP or specialist to treat a chronic condition, or has not seen their provider in the last year.
b. Individual is unable to appropriately navigate the health care system for the treatment or care of the diagnosed or undiagnosed physical or behavioral health condition.
c. Potentially preventable utilization based on flags from the RHIO, from the MCO, or in PSYCKES (such as 2 or 3+ ED visits in the past year, 1 behavioral health inpatient visit in the past year, etc)
d. Other

10. **If "other", indicate a description**
Please answer if question 9 is answered with any of the following option(s): Other

11. **Member has non-adherence to treatments or medication(s) or difficulty managing medications (define source e.g. self-reported, PSYCKES Flag or other source with knowledge)**

12. **Member has deficits in activities of daily living, learning or cognition issue (define source e.g., self-reported, reported by other, observed by HHCM, etc.) (This should not be the only risk factor)**
Select AT LEAST one option.
a. Instrumental Activities of Daily Living (IADLs) include transportation, shopping, managing finances, meal preparation, housecleaning, home maintenance, communications, and managing medications
b. Deficits caused by medication side effects, social isolation, home environment, cognitive or mental decline (e.g. dementia), aging, musculoskeletal, neurological, circulatory, sensory conditions, lack of Durable Medical Equipment, hospitalization, or acute illness
c. Other

13. **If "other", indicate a description**
Please answer if question 12 is answered with any of the following option(s): Other

14. **Member has been recently released from incarceration, detention, psychiatric hospitalization or placement; other justice referrals for those not incarcerated**
    __/__/____

15. **Risk Factor Assessment by Care Team, LGU, and/or MCO. Please explain in detail reasons why member has been authorized by Care Team, LGU, and/or MCO to be initially enrolled or to stay enrolled.**

16. **I acknowledge that I need to upload proof of eligibility into the record, including any changes to eligibility**
    Select ONE option.
    a. Yes b. No

IDENTIFICATION INFORMATION

1. **Who is present during this assessment? ****
   Select AT LEAST one option.
   a. Member b. Legally authorized representative c. Parent/Guardian
   d. Other Family e. Collateral

2. **What is member's ethnicity***
   Select ONE option.
   a. Asian b. Black c. White d. Hispanic e. Arab f. Latino
   g. Native American h. Multi-racial i. Other j. Refuses to answer

3. **If "other", indicate a description**
   Please answer if question 2 is answered with any of the following option(s): Other

4. **Primary Language***
   Select ONE option.
   a. Arabic b. Bosnian c. Chinese d. Dutch e. English f. French
   g. German h. Greek i. Haitian/French Creole j. French k. Hebrew
   l. Hindi m. Italian n. Japanese o. Korean p. Other q. Polish
   r. Russian s. Spanish t. Vietnamese u. Yiddish

5. **If "other", indicate a description** *
   Please answer if question 4 is answered with any of the following option(s): Other

6. **Is there another language spoken in the home?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer

7. **If "yes", indicate the language** *
   Please answer if question 6 is answered with any of the following option(s): Yes

8. **Is a translator, interpretative services or native language speaker needed?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer

9. **Who requires translation services? (Ensure interpretative services are addressed in the POC)** *
   Please answer if question 8 is answered with any of the following option(s): Yes

10. **Is there a preference for translation services?**

11. **What is the member's Spirituality/Faith?** *
    Select ONE option.
    a. Christianity b. Islam c. Judaism d. Hinduism e. Spiritual Beliefs
    f. Other g. Does not identify h. Refuses to answer

12. **If "other", indicate a description** *
    Please answer if question 11 is answered with any of the following option(s): Other

13. **How does the member describe their gender?** *
    Select ONE option.
    a. Male b. Female c. Transgender
    d. Does not identify as Male, Female or Transgender e. Refuses to answer

14. **transgender identification** *
    Please answer if question 13 is answered with any of the following option(s): Transgender
    Select ONE option.
    a. Transgender Male to Female b. Transgender, Female to Male
    c. Gender non-conforming d. Refuses to answer

15. **Are there any religious or cultural beliefs that you would like to share that impact your care or how you feel about receiving care? (Address how this impacts their POC)**

16. **What is the member's sexual orientation?** *
    Select ONE option.
    a. Straight b. Gay c. Lesbian d. Bisexual e. Other f. Refuses to answer

17. **If "other", indicate a description**
    Please answer if question 16 is answered with any of the following option(s): Other

18. **Is there anything else you would like to add about your sexual orientation?**

19. **Does the member or legally consented guardian have difficulty understanding or completing forms?** *
    Select ONE option.
    a. Yes b. No

20. **If yes, describe. (Remember to address on the POC)**
    Please answer if question 19 is answered with any of the following option(s): Yes

21. **Emergency Contact Info** *

22. **Additional Community Supports**

23. **I acknowledge that I need to confirm that the member's demographic information is correct and up to date in the record** *
    Select ONE option.
    a. Yes b. No

24. **Legal Guardian/Medical Consenter Name and Contact Information** *

25. **Are any other family members currently enrolled in another Health Home?**
    Select ONE option.

a. Yes b. No

26. **If Yes, family member name and relationship to child:**
Please answer if question 25 is answered with any of the following option(s): Yes

27. **Health Home Name:**
Please answer if question 25 is answered with any of the following option(s): Yes

28. **Care Management Agency Name:**
Please answer if question 25 is answered with any of the following option(s): Yes

COMPLEX TRAUMA

1. **Is the member eligible for HH services due to Complex Trauma?***
Select ONE option.
a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

2. **When was the Complex Trauma Exposure assessment completed?***
Please answer if question 1 is answered with any of the following option(s): Yes
__/__/____

3. **When was the Functional Assessment completed?** *
Please answer if question 1 is answered with any of the following option(s): Yes
__/__/____

4. **Name of the Functional Assessment**
Please answer if question 1 is answered with any of the following option(s): Yes

5. **What are the member's trauma symptoms that require care management assistance? (Refer to Functional Assessment for symptoms) (Remember to add a Goal to the POC)***
Please answer if question 1 is answered with any of the following option(s): Yes

6. **What trauma has the member experienced?***
Please answer if question 1 is answered with any of the following option(s): Yes

Select AT LEAST one option.

a. Psychological Maltreatment b. Neglect c. Displacement
d. Attachment disruption e. Sex abuse
f. Trafficking/Commercial Sexual Exploitation g. Physical Abuse
h. Domestic Violence i. Physical assault/Interpersonal violence
j. Community Violence k. War/Political Violence l. Stalking/Kidnapping
m. Bullying n. Other

7. **Date of the eligibility determination letter***
   Please answer if question 1 is answered with any of the following option(s): Yes
   __/__/____

8. **Is the licensed professional currently treating member?***
   Please answer if question 1 is answered with any of the following option(s): Yes
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Does not know/unsure

9. **Name of Licensed Professional who has completed assessments: (Add to DOH Consent Form)**
   Please answer if question 1 is answered with any of the following option(s): Yes

PATIENT STRESS QUESTIONNAIRE

Adapted from the Patient Stress Questionnaire Instructions: In your life, has the member ever had any experience that was so frightening, horrible, or upsetting that, in the past month, the member:

1. **Has had nightmares about it or thought about it when you did not want to?***
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

2. **Tried hard not to think about it or went out of your way to avoid situations that reminded the member of it?***
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

3. **Were constantly on guard, watchful, or easily startled?***
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

4. **Felt numb or detached from others, activities, or your surroundings?***
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

5. **If any of the above answers are 'yes', I acknowledge I need to discuss a possible referral for mental health services and address any issues on the POC**
   Select ONE option.
   a. Yes b. No

HIV/AIDS

1. **Has the member age 10 or older consented to share information about HIV/AIDS with the parent/guardian?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer
   d. Not age or developmentally appropriate e. Denies history

2. **Does the member engage in risk behaviors for HIV?** *
   Select AT LEAST one option.
   a. Injecting b. Unprotected sex c. History of STIs d. No
   e. Refused to answer f. Not age appropriate g. Denies history

3. **I acknowledge I need to address member engages in risk factors for HIV on the POC**
   Please answer if question 2 is answered with any of the following option(s): Injecting, Unprotected sex, History of STIs

   Select ONE option.
   a. Yes b. No

4. **Has the member ever been educated on HIV?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies
   f. Unsure

5. **Would the member like a referral for HIV education?** *
   Select ONE option.
   a. Yes (Remember to add to POC) b. No c. Refused to answer
   d. Not age appropriate e. Denies

6. **Has the member ever had an HIV test?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies

7. **When was the date of the member last test?**
   Please answer if question 6 is answered with any of the following option(s): Yes

   __/__/____

8. **Has the member engaged in risky behaviors since the member last test?** *
   Please answer if question 6 is answered with any of the following option(s): Yes

Select ONE option.
a. Yes b. No c. Refused to answer d. Not age appropriate

9. **Would the member like a referral for HIV testing?** *
Select ONE option.
a. Yes (Remember to add to POC) b. No c. Refused to answer
d. Not age appropriate e. Denies

10. **Does the member have HIV/AIDS?** *
Select ONE option.
a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies

11. **Was the member exposed to HIV Perinatally or after birth?** *
Select ONE option.
a. Perinatally b. After birth c. No known exposure

12. **Is the member receiving medical care for HIV?** *
Please answer if question 10 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies

13. **Who is providing the care? (Reminder to add to the DOH Consent and to the POC)**
Please answer if question 12 is answered with any of the following option(s): Yes

14. **What are the barriers to accessing medical care? (Remember to address the barriers on the POC)** *
Please answer if question 12 is answered with any of the following option(s): No
Select AT LEAST one option.
a. Financial b. Lack of transportation c. Need for education
d. Concerns about side effects e. Communication issues f. Lack of child care
g. None h. Other

15. **If 'other' please specify**
Please answer if question 14 is answered with any of the following option(s): Other

16. **I acknowledge that I need to address the member has barriers to accessing care for HIV on the POC**
Please answer if question 14 is answered with any of the following option(s): Financial, Lack of transportation, Need for education, Concerns about side effects, Communication issues, Lack of child care, Other

Select ONE option.
a. Yes b. No

17. **When was the member's last lab test that checked for CD4 count and Viral Load?** *
Please answer if question 10 is answered with any of the following option(s): Yes
__/__/____

18. **Does the member understand the meaning of Viral Load & CD4 count and how to read lab results?** *
Please answer if question 10 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No (Remember to address this on the POC) c. Refused to answer
d. Not age appropriate e. Denies history

19. **What is the member's current CD4 count?** *
Please answer if question 10 is answered with any of the following option(s): Yes
Select ONE option.
a. > 200 b. <= 200 c. Does not Know

20. **What is the member's current viral load?** *
Please answer if question 10 is answered with any of the following option(s): Yes

21. **Has the member's viral load been stable?** *
Please answer if question 10 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No (Remember to address this on the POC) c. Refused to answer

RISK BEHAVIORS

1. **Has the member age 10 or older consented to share information about Risk Behaviors and Factors with the parent/guardian?** *
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies History e. Not age appropriate

2. **Does the member engage in self-harming behaviors?** *
Please answer if question 1 is answered with any of the following option(s): Yes, No
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

3. **If Yes check all that apply** *
Please answer if question 2 is answered with any of the following option(s): Yes
Select AT LEAST one option.

a. Head banging b. Cutting c. Hair pulling/Trichotillomania d. Biting
e. Burning f. scratching g. Scratching h. Picking
i. Swallowing foreign objects j. Other

4. **If Other, please specify**
Please answer if question 3 is answered with any of the following option(s): Other

5. **Does the member engage in fire setting behaviors?***
Please answer if question 1 is answered with any of the following option(s): Yes, No
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

6. **When?**
Please answer if question 5 is answered with any of the following option(s): Yes
Select ONE option.
a. By history b. Within the last 3 months c. Both

7. **Was the fire setting**
Please answer if question 5 is answered with any of the following option(s): Yes
Select ONE option.
a. Intentional b. Accidental c. Both

8. **Does the member behave in a way that appears to be for positive or negative attention from adults?***
Please answer if question 1 is answered with any of the following option(s): Yes, No
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

9. **Does the member have any current at risk behavior related to suicide?***
Please answer if question 1 is answered with any of the following option(s): Yes, No
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history e. Not age appropriate

10. **If yes check all that apply**
Please answer if question 9 is answered with any of the following option(s): Yes
Select AT LEAST one option.
a. Ideation b. Plan c. Gestures/threats d. Attempts

11. **Please elaborate**
Please answer if question 9 is answered with any of the following option(s): Yes

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12. **Has the member been to the emergency room or admitted to the hospital in the past year for issues related to suicidal behavior?** *
    Please answer if question 9 is answered with any of the following option(s): Yes
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies history

13. **How many times has the member been to the ER?**
    Please answer if question 12 is answered with any of the following option(s): Yes
    Select ONE option.
    a. 0 b. 1 c. 2 d. 3 e. 4 f. 5 g. 6 h. 7 i. 8 j. 9
    k. 10 l. 11+ m. Refused to answer n. Does not know

14. **How many times has the member been admitted to the hospital?**
    Please answer if question 12 is answered with any of the following option(s): Yes
    Select ONE option.
    a. 0 b. 1 c. 2 d. 3 e. 4 f. 5 g. 6 h. 7 i. 8 j. 9
    k. 10 l. 11+ m. Refused to answer n. Does not know

15. **Does the member engage in aggressive or assaultive behaviors?** *
    Please answer if question 1 is answered with any of the following option(s): Yes, No
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies history

16. **Does the member have a history of homicidal ideation and/or threats?** *
    Please answer if question 15 is answered with any of the following option(s): Yes
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies history e. Not age appropriate

17. **Has the member ever been to the emergency room or admitted to the hospital for issues related to aggressive or assaultive behavior?** *
    Please answer if question 15 is answered with any of the following option(s): Yes
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies history

18. **How many times has the member been to the ER?**
    Please answer if question 17 is answered with any of the following option(s): Yes
    Select ONE option.
    a. 0 b. 1 c. 2 d. 3 e. 4 f. 5 g. 6 h. 7 i. 8 j. 9
    k. 10 l. 11+

19. **How many times has the member been admitted to the hospital?**
    Please answer if question 17 is answered with any of the following option(s): Yes
    Select ONE option.

a. 0 b. 1 c. 2 d. 3 e. 4 f. 5 g. 6 h. 7 i. 8 j. 9
k. 10 l. 11+

20. **Has the member harmed or threatened to harm animals?** *
Please answer if question 1 is answered with any of the following option(s): Yes, No
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

21. **Has the member engaged in any sexually aggressive behaviors towards others?** *
Please answer if question 1 is answered with any of the following option(s): Yes, No
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

22. **When?**
Please answer if question 21 is answered with any of the following option(s): Yes
Select ONE option.
a. By history b. Within the last 3 months c. Both

23. **Has the member exhibited sexually reactive behavior?** *
Please answer if question 1 is answered with any of the following option(s): Yes, No
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

24. **Is the member engaging in unprotected sex?** *
Please answer if question 1 is answered with any of the following option(s): Yes, No
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

25. **Does the member have an interest in learning more about resources available for safe sexual practices?** *
Please answer if question 24 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

26. **I acknowledge I need to create an issue in the Care Plan: Needs information on safe sexual education**
Please answer if question 24 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No

27. **Has the member engaged in runaway behaviors?** *
Please answer if question 1 is answered with any of the following option(s): Yes, No
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

28. **What is the frequency of this behavior?**
    Please answer if question 27 is answered with any of the following option(s): Yes

    Select ONE option.
    a. By history only b. Every 3-6 months c. 1-2 times a month d. Weekly

29. **When the member is AWOL are his or her whereabouts known?**
    Please answer if question 27 is answered with any of the following option(s): Yes

    Select ONE option.
    a. Always b. Often c. Sometimes d. Never

30. **Additional details**
    Please answer if question 27 is answered with any of the following option(s): Yes

31. **What are the reasons the member runs away?**
    Please answer if question 27 is answered with any of the following option(s): Yes

    Select ONE option.
    a. Conflict with caregiver b. Conflict with siblings c. Safety concerns
    d. Quality of home environment e. To spend time with peers f. Other

32. **If Other, please specify**
    Please answer if question 31 is answered with any of the following option(s): Other

33. **Have runaway behaviors ever resulted in police involvement?**
    Please answer if question 27 is answered with any of the following option(s): Yes

    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies history

34. **Does the member have any known eating disorder behaviors?***
    Please answer if question 1 is answered with any of the following option(s): Yes, No

    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies history

35. **Which behaviors does the member engage in?**
    Please answer if question 34 is answered with any of the following option(s): Yes

    Select AT LEAST one option.

a. Hoarding b. Binging c. PICA d. Withholding e. Excessive Exercising
f. Other

36. **If Other, please specify**
Please answer if question 35 is answered with any of the following option(s): Other

37. **Is the member currently involved with the juvenile justice/legal system?** *
Please answer if question 1 is answered with any of the following option(s): Yes, No

Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

38. **Does the member currently have a lawyer, probation officer, or supervision officer?** *
Please answer if question 37 is answered with any of the following option(s): Yes

Select ONE option.
a. Yes b. No

39. **If yes, would the member consent to this individual being added to the Information Sharing Consent?**
Please answer if question 38 is answered with any of the following option(s): Yes

Select ONE option.
a. Yes b. No

40. **Does the member have a history of involvement with the juvenile justice/legal system?** *
Please answer if question 1 is answered with any of the following option(s): Yes, No

Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

41. **Are there any concerns regarding physical abuse, sexual abuse, or neglect on the part of the caregiver?** *
Please answer if question 1 is answered with any of the following option(s): Yes, No

Select ONE option.
a. Yes b. No c. Currently in placement

42. **Has a call to the State Central Registry ever been made?**
Please answer if question 1 is answered with any of the following option(s): Yes, No

Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

43. **When was the most recent SCR call?**
    Please answer if question 42 is answered with any of the following option(s): Yes

    Select ONE option.
    a. In the last 6 months b. 6 months - 1 year c. 1-2 years ago
    d. More than 2 years ago

44. **Has the member ever been removed from the home as a result of an SCR report?**
    Please answer if question 42 is answered with any of the following option(s): Yes

    Select ONE option.
    a. Yes b. No

45. **If yes, when was the member removed from the home?**
    Please answer if question 44 is answered with any of the following option(s): Yes

    Select ONE option.
    a. In the last 6 months b. 6 months - 1 year c. 1-2 years ago
    d. More than 2 years ago

46. **Has the member engaged in bullying behaviors?** *
    Please answer if question 1 is answered with any of the following option(s): Yes, No

    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies history

47. **How recently have these behaviors occurred? (select one)**
    Please answer if question 46 is answered with any of the following option(s): Yes

    Select ONE option.
    a. By history b. Within the last 3 months c. Within the last month
    d. Within the last week

48. **Has the member ever been bullied?** *
    Please answer if question 1 is answered with any of the following option(s): Yes, No

    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies history

49. **How recently have these incidents occurred? (select one)**
    Please answer if question 48 is answered with any of the following option(s): Yes

    Select ONE option.
    a. By history b. Within the last 3 months c. Within the last month
    d. Within the last week

50. **Has the member ever been assessed by a counselor or doctor for the above behaviors?**
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies

51. **Is the member currently in treatment for any of these behaviors?**
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies

MENTAL HEALTH

1. **Has the member age 12 or older consented to share information about Mental Health Services with the parent/guardian?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

2. **Does the member have any behavioral/psychiatric problems/issues/diagnoses?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

3. **What are the member's mental health/behavioral/psychiatric problems/issues/diagnoses?** *
   Please answer if question 2 is answered with any of the following option(s): Yes

   Select AT LEAST one option.
   a. Anxiety Disorder b. Bi-Polar Disorder
   c. Conduct, Impulse Control and Other Disruptive Behavior Disorders
   d. Dementing Disease e. Depressive and Other Psychoses f. Eating Disorder
   g. Major Personality Disorders h. Post-Traumatic Stress Disorder (PTSD)
   i. Psychiatric Disease (Except Schizophrenia) j. Schizoaffective Disorder k. Other

4. **At what age did the member's mental health/behavioral/psychiatric problems/issues/diagnoses begin?** *
   Please answer if question 2 is answered with any of the following option(s): Yes

5. **What are the member's current symptoms? Symptom 1**
   Please answer if question 2 is answered with any of the following option(s): Yes

6. **Severity of Symptom 1**
   Please answer if question 5 is answered

   Select ONE option.
   a. 1 Not Severe b. 2 c. 3 Moderately Severe d. 4 e. 5 Extremely Severe

7. **What are the member's current symptoms? Symptom 2**
   Please answer if question 2 is answered with any of the following option(s): Yes

8. **Severity of Symptom 2**
   Please answer if question 7 is answered
   Select ONE option.
   a. 1 Not Severe b. 2 c. 3 Moderately Severe d. 4 e. 5 Extremely Severe

9. **What are the member's current symptoms? Symptom 3**
   Please answer if question 2 is answered with any of the following option(s): Yes

10. **Severity of Symptom 3**
    Please answer if question 9 is answered
    Select ONE option.
    a. 1 Not Severe b. 2 c. 3 Moderately Severe d. 4 e. 5 Extremely Severe

11. **Any additional symptoms?**

12. **Has the member been to the emergency room or admitted to the hospital in the past year for any mental health issues?** *
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

13. **Approximately how many times since the member's date of diagnosis has the member been to the ER?** *
    Please answer if question 12 is answered with any of the following option(s): Yes
    Select ONE option.
    a. 0 b. 1 c. 2 d. 3 e. 4 f. 5 g. 6 h. 7 i. 8 j. 9
    k. 10 l. 11+ m. Does not recall n. Refused to answer

14. **Approximately how many times since the member's date of diagnosis has the member been admitted to the hospital?** *
    Please answer if question 12 is answered with any of the following option(s): Yes
    Select ONE option.
    a. 0 b. 1 c. 2 d. 3 e. 4 f. 5 g. 6 h. 7 i. 8 j. 9
    k. 10 l. 11+ m. Does not recall n. Refused to answer

15. **Does the member have a psychiatrist (or psychiatric nurse practitioner)?** *
    Please answer if question 2 is answered with any of the following option(s): Yes
    Select ONE option.
    a. Yes b. No (Remember to address on POC) c. Refused to answer
    d. Pediatrician is treating e. Refused to answer f. Does not know

16. **Name of psychiatric provider. (Add to the DOH consent form)** *
Please answer if question 15 is answered with any of the following option(s): Yes, Pediatrician is treating

17. **Does the member see a therapist?** *
Please answer if question 2 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history
e. Not age appropriate f. Does not know

18. **Name of therapist. (Add to DOH consent form)** *
Please answer if question 17 is answered with any of the following option(s): Yes

19. **When did the member last see their psychiatrist (or psychiatric nurse practitioner)? Year**
Please answer if question 15 is answered with any of the following option(s): Yes
__/__/____

20. **When did the member last see their therapist?**
Please answer if question 17 is answered with any of the following option(s): Yes
__/__/____

21. **Has the member been ordered by court to attend a program?** *
Please answer if question 2 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Refused to answer d. Completed Program

22. **Please specify the program (Add to DOH Consent)**
Please answer if question 21 is answered with any of the following option(s): Yes

23. **What are the member's triggers (what people, places, or things upset the member); how does the member know when they are upset?**
Please answer if question 2 is answered with any of the following option(s): Yes

24. **When the member is upset, what activities or coping skills can they do to feel better (for example, take a walk, listen to music, watch TV)?** *
Please answer if question 2 is answered with any of the following option(s): Yes

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. **Little interest or pleasure in doing things** *
   Select ONE option.
   a. 0 Not at all b. 1 Several Days c. 2 More than half the days d. 3 Nearly every day
2. **Feeling down, depressed, or hopeless** *
   Select ONE option.
   a. 0 Not at all b. 1 Several Days c. 2 More than half the days d. 3 Nearly every day
3. **Trouble falling or staying asleep, or sleeping too much** *
   Select ONE option.
   a. 0 Not at all b. 1 Several Days c. 2 More than half the days d. 3 Nearly every day
4. **Feeling tired or having little energy** *
   Select ONE option.
   a. 0 Not at all b. 1 Several Days c. 2 More than half the days d. 3 Nearly every day
5. **Poor appetite or overeating** *
   Select ONE option.
   a. 0 Not at all b. 1 Several Days c. 2 More than half the days d. 3 Nearly every day
6. **Feeling bad about yourself - or that you are a failure and have let yourself or your family down** *
   Select ONE option.
   a. 0 Not at all b. 1 Several Days c. 2 More than half the days d. 3 Nearly every day
7. **Trouble concentrating on things, such as reading the newspaper or watching television** *
   Select ONE option.
   a. 0 Not at all b. 1 Several Days c. 2 More than half the days d. 3 Nearly every day
8. **Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual** *
   Select ONE option.
   a. 0 Not at all b. 1 Several Days c. 2 More than half the days d. 3 Nearly every day

9. **Thoughts that you would be better off dead, or of hurting yourself in some way** *
   Select ONE option.
   a. 0 Not at all b. 1 Several Days c. 2 More than half the days d. 3 Nearly every day

10. **If you marked any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?** *
    Select ONE option.
    a. Not at all b. Somewhat difficult c. Very difficult d. Extremely difficult

11. **I acknowledge that the member may be a risk for suicide and that an immediate referral for services needs to occur.**
    Please answer if question 9 is answered with any of the following option(s): 1 Several Days, 2 More than half the days, 3 Nearly every day

    Select ONE option.
    a. Yes b. No

MEDICAL

1. **Does the member have any medical problems/issues/diagnoses?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Denies history

2. **What are the member's medical problems/issues/diagnoses?** *
   Please answer if question 1 is answered with any of the following option(s): Yes

   Select AT LEAST one option.
   a. Alcohol Addiction b. Drug Addiction c. Opioid Addiction
   d. Other Addiction e. Advanced Coronary Artery Disease
   f. Alcohol and Liver Disease g. Asthma h. Cerebrovascular Disease
   i. Chronic Alcohol Abuse j. Chronic Obstructive Pulmonary Disease
   k. Chronic Renal Failure l. Cocaine Abuse m. Congestive Heart Failure
   n. Diabetes o. Drug Abuse p. Hepatitis C q. HIV/AIDS r. Hypertension
   s. Kidney/Renal Disease t. Obesity u. Opioid Abuse
   v. Other Significant Drug Abuse w. Peripheral Vascular Disease x. Pregnancy
   y. Other

3. **If Other, please explain**
   Please answer if question 2 is answered with any of the following option(s): Other

   ____

4. **What are the member's current symptoms? Symptom 1**
   Please answer if question 1 is answered with any of the following option(s): Yes

   ____

5. **Severity of Symptom 1**
Please answer if question 4 is answered
Select ONE option.
a. 1 Not Severe b. 2 c. 3 Moderately Severe d. 4 e. 5 Extremely Severe

6. **What are the member's current symptoms? Symptom 2**
Please answer if question 1 is answered with any of the following option(s): Yes

7. **Severity of Symptom 2**
Please answer if question 6 is answered
Select ONE option.
a. 1 Not Severe b. 2 c. 3 Moderately Severe d. 4 e. 5 Extremely Severe

8. **What are the member's current symptoms? Symptom 3**
Please answer if question 1 is answered with any of the following option(s): Yes

9. **Severity of Symptom 3**
Please answer if question 8 is answered
Select ONE option.
a. 1 Not Severe b. 2 c. 3 Moderately Severe d. 4 e. 5 Extremely Severe

10. **Other Symptoms**
Please answer if question 1 is answered with any of the following option(s): Yes

11. **Are any of the member's medical issues bothering them especially/more than usual right now?** *
Please answer if question 1 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

12. **Please specify (Remember to add a POC issue regarding uncontrolled or poorly controlled symptoms)**
Please answer if question 11 is answered with any of the following option(s): Yes

13. **Is there anything that the CM can do to assist you with your current medical issues?**

14. **Has the member been to the emergency room or admitted to the hospital in the past year for any of those issues?** *
    Please answer if question 1 is answered with any of the following option(s): Yes
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies history

15. **How many times in the past year has the member been to the ER?**
    Please answer if question 14 is answered with any of the following option(s): Yes
    Select ONE option.
    a. 0 b. 1 c. 2 d. 3 e. 4 f. 5 g. 6 h. 7 i. 8 j. 9
    k. 10 l. 11+ m. Refused to answer n. Does not recall

16. **How many times in the past year has the member been admitted to the hospital?**
    Please answer if question 14 is answered with any of the following option(s): Yes
    Select ONE option.
    a. 0 b. 1 c. 2 d. 3 e. 4 f. 5 g. 6 h. 7 i. 8 j. 9
    k. 10 l. 11+ m. Refused to answer n. Does not recall

17. **Does the member have a primary care doctor or any medical specialists?** *
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies history e. Does not know

18. **Name(s) of primary care doctor and specialists (Add to DOH Consent)**

19. **When did the member last see their PCP or medical specialist?**
    Please answer if question 17 is answered with any of the following option(s): Yes
    __/__/____

20. **For members who are self-consenting: Decisions about health and medical care can be so complicated. Is there someone in the member's life that the member has identified or formally designated who would help the member make decisions about the member's health care if the member were unable to make those decisions for themselves?**
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Not age appropriate

21. **Enter Contact Information for Medical Proxy**
    Please answer if question 20 is answered with any of the following option(s): Yes

22. **Is this something the member would like to learn more about?**
Please answer if question 20 is answered with any of the following option(s): No

Select ONE option.
a. Yes (Remember to address this on the POC) b. No c. Refused to answer
d. Not age appropriate

23. **Are there any problems with mobility?** *
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies any history

24. **Please describe**
Please answer if question 23 is answered with any of the following option(s): Yes

25. **Are there special dietary needs?** *
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

26. **Please describe**
Please answer if question 25 is answered with any of the following option(s): Yes

27. **Are immunizations up to date?** *
Select ONE option.
a. Yes b. No c. Refused to answer d. Does not know

28. **When did the member last see their dentist?** *
Select ONE option.
a. Within the last 6 months b. Within the last year c. More than a year
d. Does not have a dentist

29. **What are the member's current dental concerns and needs?**
Select AT LEAST one option.

a. Routine care b. Reports pain c. Gum disease d. Tooth decay
e. Orthodontics f. Phobia g. Does not have dental concerns

MEDICATIONS

1. **Is the member currently prescribed medication?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Denies history

2. **Does the member take over the counter medications?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Denies history

3. **Confirm Medication List is completed and uploaded into the record**
   Please answer if question 1 is answered with any of the following option(s): Yes
   Select ONE option.
   a. Yes b. No

4. **Does the member understand the reason for each medication?** *
   Please answer if question 1 is answered with any of the following option(s): Yes
   Select ONE option.
   a. Yes b. No c. Refused to answer

5. **I acknowledge I need to address member does not have an understanding of medications on the POC**
   Please answer if question 4 is answered with any of the following option(s): No
   Select ONE option.
   a. Yes b. No

6. **Does the member ever have problems taking or remembering to take their medications?** *
   Please answer if question 1 is answered with any of the following option(s): Yes
   Select ONE option.
   a. Yes, for medical conditions only b. Yes, for behavioral health conditions only
   c. Yes, for both medical and behavioral health conditions d. Refused to answer
   e. Denies history f. No

7. **What difficulties does the member experience taking their medication as prescribed?**
   Please answer if question 6 is answered with any of the following option(s): Yes, for medical conditions only, Yes, for behavioral health conditions only, Yes, for both medical and behavioral health conditions
   Select AT LEAST one option.

a. Financial b. Lack of transportation c. Need for Psychoeducation
d. Concerns about the side effects e. Communication issues f. Provider issues
g. Lack of Child Care h. Child declines

8. **I acknowledge I need to address member has barriers to taking medications on the POC**
   Select ONE option.
   a. Yes b. No

9. **Name and location of Pharmacy**

10. **Does the member have allergies?** *
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies history

11. **Please enter the member's allergies, including the type and reaction**
    Please answer if question 10 is answered with any of the following option(s): Yes

SUBSTANCE USE

1. **Has the member age 10 or older consented to share information about Substance Use Disorder with the parent/guardian?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Denies history e. Not age appropriate

2. **Has the member used Alcohol or Drugs within the past 12 months?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

3. **Has the member ever gone to anyone for help for a drug or alcohol issue?** *
   Please answer if question 2 is answered with any of the following option(s): Yes
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Denies history

4. **If yes, who?**
   Please answer if question 3 is answered with any of the following option(s): Yes

5. **Has the member, in the past, been treated for problems related to drug or alcohol**

abuse?*

Select AT LEAST one option.

a. Yes - crisis services - medically supervised withdrawal (detox) - inpatient
b. Yes - inpatient treatment services (30 day rehab)
c. Yes - methadone treatment - methadone clinic
d. Yes - outpatient services - outpatient clinic
e. Yes - outpatient services - outpatient rehabilitation f. Yes - residential services g. No

6. **Is the member currently involved in an outpatient treatment program specifically related to drug or alcohol use?***

Please answer if question 2 is answered with any of the following option(s): Yes

Select ONE option.

a. Yes - Methadone b. Yes - Suboxone c. Yes - treatment - Methadone Clinic
d. Yes - outpatient services - outpatient clinic
e. Yes - outpatient services - outpatient rehabilitation f. No

7. **Enter treatment provider. Include treatment provider on DOH consent if current.**

Please answer if question 3 is answered with any of the following option(s): Yes

8. **Has the member ever been in a hospital for medical issues related to their drug or alcohol use?***

Select ONE option.

a. Yes b. No c. Refused to answer d. Denies history

9. **When was the last time the member was in a hospital for an issue related to their drug or alcohol use?**

Please answer if question 8 is answered with any of the following option(s): Yes

__/__/____

10. **Does the member smoke cigarettes, vape, or use other tobacco products?***

Select ONE option.

a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

11. **Would the member like information about, or a referral for, smoking cessation?**

Please answer if question 10 is answered with any of the following option(s): Yes

Select ONE option.

a. Yes (Remember to address this on the POC) b. No c. Refused to answer

CRAFFT SCREENING INTERVIEW

I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential.

1. **During the PAST 12 MONTHS, did you: Drink any alcohol (more than a few sips)? Do not count sips of alcohol taken during family or religious event.**
   Select ONE option.
   a. Yes b. No
2. **During the PAST 12 MONTHS, did you smoke any marijuana or hashish?**
   Select ONE option.
   a. Yes b. No
3. **During the PAST 12 MONTHS, did you Use anything else to get high? anything else' includes illegal drugs, over the counter and prescription drugs, and things that you sniff or 'huff'.**
   Select ONE option.
   a. Yes b. No
4. **Have you ever ridden in a CAR driven by someone (including yourself) who was 'high' or had been using alcohol or drugs?**
   Select ONE option.
   a. Yes b. No
5. **Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?**
   Select ONE option.
   a. Yes b. No
6. **Do you ever use alcohol or drugs while you are by yourself, or ALONE?**
   Select ONE option.
   a. Yes b. No
7. **Do you ever FORGET things you did while using alcohol or drugs?**
   Select ONE option.
   a. Yes b. No
8. **Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?**
   Select ONE option.
   a. Yes b. No
9. **Have you ever gotten into TROUBLE while you were using alcohol or drugs?**
   Select ONE option.
   a. Yes b. No
10. **Were 2 or more questions answered 'Yes'**
    Select ONE option.
    a. Yes b. No
11. **Create an issue in the Care Plan: Member is at risk for substance abuse**
    Please answer if question 10 is answered with any of the following option(s): Yes
    Select ONE option.

a. Yes b. No

DEVELOPMENT

1. **Are there any concerns about the member's development?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history
2. **Type of delay**
   Please answer if question 1 is answered with any of the following option(s): Yes
   Select AT LEAST one option.
   a. Cognitive b. Communication c. Adaptive d. Social-emotional
   e. Physical Development
3. **Is there documentation of the developmental delay?**
   Select ONE option.
   a. Yes b. No c. Does not know
4. **Date of last assessment**
   Please answer if question 3 is answered with any of the following option(s): Yes
   Select ONE option.
   a. Known b. Does not know
5. **Date**
   Please answer if question 4 is answered with any of the following option(s): Known
   __/__/____
6. **How many days per week does the member receive therapy/services?**
   Please answer if question 3 is answered with any of the following option(s): Yes
   Select ONE option.
   a. 0 b. 1 c. 2 d. 3 e. 4 f. 5 g. 6
7. **Are there any risks associated with developmental conditions?**
   Please answer if question 3 is answered with any of the following option(s): Yes
   Select AT LEAST one option.
   a. Social vulnerability b. Physical concerns c. Financial d. Wandering
   e. Academic f. Other g. None
8. **Are referrals or supports needed?**
   Please answer if question 3 is answered with any of the following option(s): Yes
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Denies history e. Not age appropriate

9. **Enter additional referrals or support required**
   Please answer if question 8 is answered with any of the following option(s): Yes

10. **I acknowledge I need to create an issue in the Care Plan: Needs referral/support for developmental delays**
    Please answer if question 8 is answered with any of the following option(s): Yes
    Select ONE option.
    a. Yes b. No

11. **Is this member receiving Early Intervention services?**
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

12. **How many days per week does the member receive EI services?**
    Please answer if question 11 is answered with any of the following option(s): Yes
    Select ONE option.
    a. 1 b. 2 c. 3 d. 4 e. 5 f. 6

13. **Which developmental milestones aren't within normal limits?**
    Please answer if question 11 is answered with any of the following option(s): Yes
    Select AT LEAST one option.
    a. Grasp items b. Lift head c. Crawling d. Talking 1-2 word sentences
    e. Talking 3-4 word sentences f. Sit with support g. Walking
    h. Potty trained i. Other

14. **If Other, please specify**
    Please answer if question 13 is answered with any of the following option(s): Other

15. **Does the member have a history of receiving EI services?**
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Not age appropriate
    e. Denies history f. Unknown

16. **Additional information pertaining to member's development**

ACADEMICS

1. **Is the member attending school?** *
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

2. **School Name**
   Please answer if question 1 is answered with any of the following option(s): Yes

3. **Grade**
   Please answer if question 1 is answered with any of the following option(s): Yes

4. **What is the member's school setting?** *
   Please answer if question 1 is answered with any of the following option(s): Yes
   Select ONE option.
   a. School b. Alternative Program c. GED d. College Prep e. College

5. **What educational services is the member receiving?**
   Please answer if question 1 is answered with any of the following option(s): Yes
   Select ONE option.
   a. General education b. Special education c. Referral for CSE Evaluation needed

6. **What is the member's attendance frequency?** *
   Please answer if question 1 is answered with any of the following option(s): Yes
   Select ONE option.
   a. Typically present daily b. One-two absences a month
   c. One absence per week or more d. Cuts classes
   e. Appointments interfering with school f. Not attending

7. **I acknowledge I need to create an issue in the Care Plan: Member has inconsistent school attendance**
   Please answer if question 6 is answered with any of the following option(s): One-two absences a month, Cuts classes, Appointments interfering with school, Not attending
   Select ONE option.
   a. Yes b. No

8. **What is the member's typical behavior at school?**
Please answer if question 1 is answered with any of the following option(s): Yes
Select ONE option.
a. No issues reported b. Positively adjusted to school environment
c. Behavior is impacting on learning d. Behavior is at risk of supension

9. **What resources at the school do you communicate with or have a good working relationship with?**
Please answer if question 1 is answered with any of the following option(s): Yes

10. **Does the member meet with any staff, clubs or groups to assist with academics or socialization?**
Please answer if question 1 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

11. **If yes, describe**
Please answer if question 10 is answered with any of the following option(s): Yes

12. **Can the member get to the bus stop without assistance?**
Please answer if question 1 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Refused to answer d. Not age appropriate

13. **Are there any safety issues with walking or taking the bus to school?**
Please answer if question 1 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Refused to answer d. Denies history

14. **Are the member's needs being addressed by their school?**
Please answer if question 1 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Refused to answer

15. **If the member is 17 or older who are not currently enrolled: Is the member interested**

in completing any more education or have interest in a skilled trade certificate program?*
Select ONE option.
a. Yes b. No c. Refused to answer d. Not age appropriate

16. **Is advocacy needed?**
Select ONE option.
a. Yes (Reminder to address this on the POC) b. No c. Refused to answer
d. Not age appropiate e. Denies history

INDEPENDENT LIVING

1. **Is the member 14 years old or older?***
Select ONE option.
a. Yes b. No

2. **Is the member currently employed?***
Please answer if question 1 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Refused to answer

3. **Is the member interested in getting a job?**
Please answer if question 2 is answered with any of the following option(s): No
Select ONE option.
a. Yes b. No c. Refused to answer

4. **I acknowledge I need to create an issue in the Care Plan: Would like to get a job**
Please answer if question 3 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No

5. **In the past 7 days, did the member need help from others to perform every day activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?***
Select AT LEAST one option.
a. Eating b. Getting dressed c. Grooming d. Bathing e. Walking
f. Using the toilet g. Not age appropriate h. Other i. None

6. **If Other, please specify**
Please answer if question 5 is answered with any of the following option(s): Other

7. **Who helped the member with the tasks checked above?**
   Please answer if question 5 is answered with any of the following option(s): Eating, Getting dressed, Grooming, Bathing, Walking, Using the toilet, Other

   Select AT LEAST one option.
   a. Relative b. Friend c. Neighbor d. Home Attendant e. Foster parent
   f. No one g. Other

8. **If Other, please specify**
   Please answer if question 5 is answered with any of the following option(s): Other

9. **I acknowledge I need to create an issue in the Care Plan: Requires assistance with activities of daily living**
   Please answer if question 5 is answered with any of the following option(s): Eating, Getting dressed, Grooming, Bathing, Walking, Using the toilet, Other

   Select ONE option.
   a. Yes b. No

10. **In the past 7 days, did the member need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking their own medications?***
    Select AT LEAST one option.
    a. Laundry and housekeeping b. Banking c. Shopping
    d. Using the telephone e. Food preparation f. Transportation
    g. Taking the member's own medications h. Not age appropriate i. Other j. None

11. **If Other, please specify**
    Please answer if question 10 is answered with any of the following option(s): Other

12. **Who helped the member with the tasks checked above?**
    Please answer if question 10 is answered with any of the following option(s): Laundry and housekeeping, Banking, Shopping, Using the telephone, Food preparation, Transportation, Taking the member's own medications, Other

    Select AT LEAST one option.

a. Relative b. Friend c. Neighbor d. Home Attendant e. Foster Parent
f. No One g. Other

13. **If Other, please specify**
Please answer if question 12 is answered with any of the following option(s): Other

14. **I acknowledge that I need to create an issue in the Care Plan: Requires assistance with instrumental activities of daily living**
Please answer if question 10 is answered with any of the following option(s): Laundry and housekeeping, Banking, Shopping, Using the telephone, Food preparation, Transportation, Taking the member's own medications, Other

Select ONE option.
a. Yes b. No

15. **Does the member require use of adaptive equipment/technology?**
Select ONE option.
a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

16. **If Yes, specify the equipment/technology**
Please answer if question 15 is answered with any of the following option(s): Yes

17. **Contact(s) of who helps member with IADLs (Add to DOH consent)**

18. **Are there any safety concerns regarding any of the issues discussed above?***
Select ONE option.
a. Yes b. No c. Refused to answer d. Not age appropriate e. Denies history

SOCIAL SERVICE NEEDS

1. **Is the member/family involved with any of the following?***
   Select AT LEAST one option.
   a. Open ACS/CPS Investigation b. Family Support Unit of ACS (Formerly COS)
   c. Foster Care d. Prevention e. Person in Need of Supervision (PINS) f. None

2. **What type of housing does the member currently reside in?** *
   Select ONE option.
   a. Congregate Care b. Public c. Private d. Supportive Housing
   e. Shelter f. Street Homeless g. Temporary Housing

3. **Is there any risk that the member's housing/living arrangement may be unstable?***
   Please answer if question 2 is answered with any of the following option(s): Congregate Care, Public, Private, Supportive Housing

   Select ONE option.
   a. Yes b. No c. Refused to answer

4. **If yes, potential cause?**
   Please answer if question 3 is answered with any of the following option(s): Yes

   Select AT LEAST one option.
   a. Financial b. Safety Transfer c. Foster placement in jeopardy
   d. Quality of housing e. Environmental conditions f. Crime/Risk of violence
   g. Legal involvement

5. **Who resides with the member and their relationship to member?**

6. **How many times has the member moved in the last 6-12 months?**
   Select ONE option.
   a. 0 b. 1-3 times c. 4+ times

7. **How many of these moves have been related to foster care transitions?**
   Please answer if question 6 is answered with any of the following option(s): 1-3 times, 4+ times

   Select ONE option.
   a. All b. None c. 1-3 d. 4+ times

8. **Has the member ever been homeless?***
   Select ONE option.
   a. Yes b. No c. Refused to answer d. Denies history

9. **Does the member's current household receive any of the following income sources?** *
   Select AT LEAST one option.
   a. SSD/SSDI b. PA/HASA c. Section 8 d. FEPS e. MRT Housing
   f. Child Support g. WIC h. SNAP i. Foster Care Subsidy
   j. Adoption Subsidy k. Unemployment Insurance l. Employment m. None
   n. Other

10. **Does the member's current household need any of the following benefits/**

entitlements?
Select AT LEAST one option.
a. SSI/SSDI b. PA/HASA c. Section 8 d. FEPS e. MRT Housing Subsidy
f. Child Support g. WIC h. SNAP i. Foster Care Subsidy
j. Unemployment Insurance k. None

11. **I acknowledge I need to create an issue in the Care Plan: Member's current household needs entitlements***
Please answer if question 10 is answered with any of the following option(s): SSI/SSDI, PA/HASA, Section 8, FEPS, MRT Housing Subsidy, Child Support, WIC, SNAP, Foster Care Subsidy, Unemployment Insurance
Select ONE option.
a. Yes b. No

12. **Does the member have financial supports/representative payee?***
Select ONE option.
a. Yes b. No c. Member is currently under 18 years old

13. **If yes, would the member consent to this individual being added to the Information Sharing Consent?**
Please answer if question 12 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Refused to answer

14. **Does the member have supplemental medical insurance?***
Select ONE option.
a. Yes b. No c. Refused to answer

15. **Which Insurance?**
Please answer if question 14 is answered with any of the following option(s): Yes

16. **With reference to food security, are there concerns regarding the following:***
Select AT LEAST one option.
a. Access to healthy food b. Ability to afford adequate amount of food
c. Quality of diet d. Access to school meals
e. Availability of food resources/pantries f. None

17. **I acknowledge that I need to create an issue in the Care Plan: Member is food insecure**
Please answer if question 16 is answered with any of the following option(s): Access to healthy food, Ability to afford adequate amount of food, Quality of diet, Access to school meals, Availability of food resources/pantries
Select ONE option.
a. Yes b. No

18. **Does the member have adequate access to transportation?***
    Select ONE option.
    a. Yes b. No c. Refused to answer

19. **I acknowledge that I need to create an issue in the Care Plan: Member needs transportation**
    Please answer if question 18 is answered with any of the following option(s): No
    Select ONE option.
    a. Yes b. No

20. **What is the member's primary mode(s) of transportation?**
    Select ONE option.
    a. Subway/bus b. Access A Ride c. Medicaid Transportation d. Medical e. Transportation f. Private Vehicle g. None

21. **Are any special transportation accommodations needed? If so, which?**
    Select ONE option.
    a. Wheelchair accessible b. Stetcher c. 1:1 Support d. None

22. **Does the member/family have any concerns regarding immigration/legal status?**
    Select ONE option.
    a. Yes b. No c. Refused to answer d. Denies history

23. **Would the member/family like assistance with these concerns?**
    Please answer if question 22 is answered with any of the following option(s): Yes
    Select ONE option.
    a. Yes b. No c. Refused to answer

24. **I acknowledge that I need to create an issue in the Care Plan: Member/family has immigration concerns**
    Please answer if question 23 is answered with any of the following option(s): Yes
    Select ONE option.
    a. Yes b. No

25. **The child's Transition Plan including circumstances/services needed to transition from Health Home Care Management as needed (e.g., education, living situation, employment, community functioning, hospital, treatment facility, foster care)**