Provider Policy Guide

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Introduction

The purpose of the CareLink NM Provider Policy Manual is to provide a reference for the policies established by the New Mexico Human Services Department (HSD) for the administration of the CareLink NM Health Home (CareLink NM) program. The Manual was developed by the Medical Assistance Division (MAD) of HSD to assist in the administration of CareLink NM. Specifically, the Manual is intended to provide direction to the agencies who serve as CareLink NM Providers.

CareLink NM is a set of services authorized by Section 2703 of the Patient Protection and Affordable Care Act (P.L. 111-148, ACA). Care Link NM services are delivered through a designated provider agency (CareLink NM provider agency) to enhance the integration and the coordination of primary, acute, behavioral health, and long-term services and supports. The CareLink NM provider agency assists a CareLink NM Member (CLNM Member) by engaging him or her through more direct relationships and intensive care coordination resulting in a comprehensive (Needs Assessment) and plan of care (CareLink NM Plan). The provider agency also increases access to health education and promotion activities, monitors the CLNM Member's treatment outcomes and utilization of resources, coordinates appointments with primary care and specialty practitioners, shares information among his or her physical and behavioral health practitioners to reduce the duplication of services, actively manages the transitions between services, and participates as appropriate in the development of the CLNM Member's hospital discharge plan.

Authority

New Mexico implemented Centennial Care in 2014 to modernize New Mexico's Medicaid program, and is pursuing the opportunity to develop a Health Home benefit for some of the most vulnerable members of New Mexico's population. The mission of CareLink NM is to promote self-management of care choices through a supportive learning environment and provide expanded support services such as case management and care coordination for all physical health, behavioral health, long-term care and other social needs such as housing, transportation, and employment. CareLink NM will provide integrated care for Medicaid recipients and managed care organization (MCO) Members with chronic conditions, targeting a vulnerable population with behavioral health needs. The first phase of CareLink NM is for Medicaid eligible adults with serious mental illness (SMI) and for children and adolescents with a severe emotional disturbance (SED).

The policies in this Manual may be amended and will be reviewed on a periodic basis to determine needed changes. HSD reserves the right to change, modify or supersede any of these policies and procedures. As policies are revised, they will be incorporated into the Manual. The Manual may be viewed or downloaded from MAD's home page website at www.hsd.state.nm.us.

The Manual is intended to provide guidance. It will be issued and maintained by HSD. It is the responsibility of all entities affiliated with CareLink NM to review and be familiar with this Manual.

Introduction to the Health Home Model

Overview

HSD is leading the statewide initiative to provide coordinated care by a Health Home through CareLink NM for individuals with the aforementioned chronic conditions and all associated co-morbidities. The CareLink NM service delivery model will enhance integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons with chronic illness across the lifespan. The CareLink NM model enhances the efforts made through the development and implementation of the Centennial Care program to improve integrated care and enhance Member engagement in managing their health. In New Mexico's health home model, CareLink NM provider agencies will enhance their current operating structure to provide care coordination, partner with physical health providers and specialty providers while utilizing health information technology (HIT) to monitor care and provide comprehensive record management to serve FFS recipients and MCO Members already receiving behavioral health services as well as new individuals who elect, and are eligible to participate.

The CareLink NM Health Home will integrate with, and not duplicate services currently offered in Centennial Care. HSD's vision is to educate FFS recipients and MCO Members to become more knowledgeable health care consumers, to promote more integrated care, and to properly manage at-risk CLNM Members and involve CLNM Members in their own wellness. CareLink NM also provides an opportunity for the State to provide intensive care coordination to some Medicaid FFS recipients.

Core Service Definitions

The CLNM provider agency must demonstrate the ability to provide all core services described in this Manual and meet all data and quality reporting requirements. The provider agency may elect to meet the service needs of CLNM Members by providing integrated physical and behavioral health services through an on-site, colocation model, or through a memorandum of agreement (MOA) with at least one primary care practice in the area that serves CLNM Members under 21 years of age, and one that serves CLNM Members 21 years of age and older. The provider agency must also have established referral and service protocols with the area hospitals and residential treatment facilities.

Services that a provider agency must deliver to CLNM Members consist of six core service categories. These categories include Comprehensive Care Management, Care Coordination and Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, Community and Social Support Service Referrals, and use of Health Information Technology (HIT). The following sections describe the six core service categories in greater detail.

Comprehensive Care Management

Comprehensive care management must include:

- Assessment of preliminary risk conditions and health needs;
- Development of CareLink NM Plans, which will include CLNM Members' goals, preferences and optimal clinical outcomes and the identification of specific additional health screenings required based on the individual's risk assessment;
- Assignment of health team roles and responsibilities;
- Development of treatment guidelines for health teams to follow across risk levels or health conditions;
- Oversight of the implementation of CareLink NM Plans which bridge treatment and wellness support across behavioral health and primary care;
- Monitoring of Members' health status and service use to determine adherence to or variance from treatment guidelines and treatment plan goals and objectives through claims-based data sets and patient registries; and
- Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

Care Coordination and Health Promotion

Care coordination is the implementation of the individualized, culturally appropriate CareLink NM Plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports. The CareLink NM Plan is always developed in active partnership with the CLNM Member and his/her family, as appropriate. Care coordination promotes integration and cooperation among service providers and reinforces treatment strategies that support the CLNM Member's motivation to better understand and actively self-manage his or her health condition.

Care coordination and health promotion services must include, but are not limited to:

- Scheduling appointments
- Conducting face-to-face visits with Members;
- Conducting referrals and follow-up monitoring;
- Participating in hospital discharge processes and communicating with other providers and CLNM Members and their family members;
- Delivering health education specific to the CLNM Member's chronic conditions;
- Developing self-management plans with the CLNM Member;
- Educating CLNM Members about the importance of immunizations and screening for overall general health;
- Providing support for improving social networks; and
- Providing health-promoting lifestyle interventions, including but not limited to: substance use prevention and/or reduction; resiliency and recovery, independent living, smoking prevention and cessation; nutritional counseling, obesity reduction and prevention and increasing physical activity.

Health promotion activities also assist CLNM Members to participate in the implementation of both their treatment and medical services plans and place strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. Health promotion reinforces strategies that support the CLNM Member's motivation to better understand and actively self-manage his or her chronic health condition.

Comprehensive Transitional Care

Health Homes are responsible for taking a lead role in transitional care. Comprehensive transitional care is bi-directional and begins with diverting CLNM Members from having to access levels of care such as emergency department services, residential treatment and inpatient hospitalization. Comprehensive transitional care from hospital inpatient to other settings, including appropriate follow-up care may include the following services:

- Coordination of the CareLink NM Plan;
- Implementing appropriate services and supports to reduce hospital admissions and readmissions;
- Facilitating the transition to long term services and supports;
- Interrupting patterns of frequent hospital emergency department use;
- Collaborating with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the CareLink NM Plan or modify it as appropriate;
- Enhancing CLNM Member's, their family's and other supports' ability to manage care and live safely in the community; and
- Increasing the use of proactive health promotion and self-management.

Individual and Family Support Services

Goals of the individual and family support services are: to increase a CLNM Member's health and medication literacy; to enhance a CLNM Member's ability to self-manage care; to promote family involvement and support; to improve access to education and employment supports; and to strengthen the individual's ability to revise and update their CareLink NM Plan. Overall, individual and family support engagement activities should support recovery and resiliency.

Individual and family support services must include, but are not limited to:

- Navigating the health care system to access needed services for CLNM Member and families;
- Assisting with obtaining and adhering to medications and other prescribed treatments;
- Identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in their community; and
- Arranging for transportation to medically necessary services.

Referral to Community and Social Support Services

Provider agencies will identify available community-based resources and actively link and manage appropriate referrals to care and community support services. Linkages will reflect the personal needs of the client and will be consistent with recovery goals and the CareLink NM Plan. Provider agencies will also ensure that these connections are solid and effective.

Community and Social Support Service referral activities may include, but are not limited to, the following:

- Identifying available community-based resources such as legal services, housing, educational supports, employment supports, recovery and treatment plan goals support;
- Actively managing appropriate referrals and access to care;
- Providing engagement with other community and social supports; and
- Following up with facilities post-engagement.

Use of Health Information Technology to Link Services

The provider agency will be responsible for using HIT to link services, as feasible and where appropriate. The assessments, CareLink NM Plan, critical planning and transition documents, and MCO or FFS utilization information will be available via web-based tools or they may be shared via secure data exchange, email or hard copy.

As outlined in the Health Information Technology section later in the Manual, the BHSDStar web-based data collection tool will be used to create participant records that are specific to CareLink NM. BHSDStar will also eventually provide support for the bidirectional data exchange of the records created in this tool for this project.

BHSDStar will be developed in modules and will be used to collect and share information for tracking and care integration, such as:

- Tracking of calls, referrals, follow up, and prior authorizations;
- Tracking of beneficiary's CareLink NM opt in/opt out status and data sharing agreement related to the program;
- Goals identified as a part of the CareLink NM Plan;
- Daily census of ER and urgent/planned/pre-authorized admission activities identified by the State and/or the MCO provided to the Health Home;
- Progress information related to identified health action goals and progress on care plan outcomes;
- Changes in CareLink NM enrollment in Medicaid or CareLink NM;
- Completing and monitoring Needs Assessments; and
- Data collection to support quality indicators measuring program success.

In addition to these BHSDStar tools, HSD will use its existing Predictive Risk Intelligence System (PRISM) web-based clinical decision support predictive modeling tool to provide critical insights via a claims-based view of the health service utilization of CareLink NM beneficiaries. The key features of the PRISM application include:

- A claims-based view of the health service experiences of CareLink NM participants which contains comprehensive longitudinal health information derived from paid claims and managed care encounters;
- Integration of medical and behavioral health data to provide a comprehensive view of patient risk factors, service utilization and health outcomes;
- State-of-the-art predictive modeling to identify patients at greatest risk of high future medical costs or hospitalization. PRISM also predicts and assesses the extent to which emergency department visits are potentially avoidable;
- Risk scoring algorithms that are calibrated to New Mexico's Medicaid client populations by the PRISM team;
- Medication adherence dashboard to identify patients who may be at risk due to low adherence, psychotropic polypharmacy or narcotic addiction;
- Weekly data updates. Predictive modeling scores for the entire Medicaid population are recalculated on a weekly basis to reflect changes in patient service events and patient risk factors; and
- Robust security measures to protect patient data security and privacy.

Target Populations

The target populations of the CareLink NM program are individuals enrolled in Medicaid, including Medicaid recipients in FFS and MCO Members, who are diagnosed with one or more serious mental illness (SMI) or severe emotional disturbance (SED) as defined by the State of New Mexico. The CareLink NM program will be implemented in a phased approach based on geographic residency of the eligible CLNM Member. In order to be eligible for enrollment in CareLink NM on April 1, 2016, an individual must be enrolled in Centennial Care or Medicaid FFS, have one or more SMI or SED, and reside in a county approved by the Centers for Medicare & Medicaid Services (CMS) through a State Plan Amendment (SPA). Initial counties of residence approved by CMS for enrollment on April 1, 2016 are Curry County and San Juan County. In the future, HSD may expand the list of approved counties and/or eligible chronic conditions.

Provider Requirements

Providers eligible for a CareLink NM provider agency designation include Federally Qualified Health Centers (FQHCs), Indian Health Services (IHS) hospitals or clinics, P.L. 93-638 tribally operated hospitals or clinics, Core Service Agencies (CSAs), Behavioral Health Agencies (BHAs), or Community Mental Health Centers (CMHCs). In general, a provider agency is required to deliver comprehensive, integrated, high-quality care that operates under a whole-person model. Eligible providers must also meet the following provider standards and qualification criteria in order to enroll as a provider agency.

In New Mexico, the following criteria are standards and qualification requirements of CareLink NM provider agencies:

a. Registered as a Medicaid Provider in the State of New Mexico;
b. Holds a Comprehensive Community Support Services (CCSS) certification from the State of New Mexico;
c. Employs the following staff with the requisite qualifications:

i. Health Home Director;
ii. Health Promotion Coordinator-relevant bachelors level degree, experience developing and delivering curriculum;
iii. Care Managers-Licensed or bachelors or master's degree in a human services field with experience approved by HSD;
iv. Community Liaison-multilingual and experienced with local community resources;
v. Clinical Supervisor-independently licensed with adult and pediatric experience;
vi. Peer Support Specialists-certified by state;
vii. Medical Consultant; and
viii. Psychiatric Consultant.

d. Ability to meet all data collection, quality and reporting requirements.

The following best practices are identified as fundamental to facilitate the success of CareLink NM:

a. Provide quality-driven, cost-effective, culturally appropriate, and person and family centered health homes services;
b. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
d. Coordinate and provide access to mental health services:
e. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings to include appropriate follow up from inpatient to other settings, participate in discharge planning and facilitate transfer from pediatric to adult health care system;
f. Coordinate and provide access to disease management for chronic illnesses and all co-morbidities, including self-management supports to individuals and to their families;
g. Coordinate and provide access to community referrals, social supports and recovery services;
h. Coordinate and provide access to long-term care supports and services;
i. Develop a CareLink NM Plan for each individual that integrates the whole-person model of healthcare needs and services;
j. Demonstrate a capacity to use HIT to link services, facilitate communication between team members, providers, CLNM Member and families; and
k. Establish a continuous quality improvement program and have the ability to collect and report on data to evaluate effectiveness of CLNM Member outcomes.

Participation Requirements for Providers

Enrollment as a Medicaid Provider

Services provided to CLNM Members are furnished by a variety of providers and provider groups. A CareLink NM provider agency must first be enrolled as a New Mexico Medicaid provider and meet all applicable standards. A provider enrolls as a Medicaid provider by successfully completing an existing application process, which consists of a provider participation agreement (PPA) established by MAD. In addition to being enrolled as a Medicaid provider, the CareLink NM provider agency applicant must also meet the other provider qualifications and standards outlined in this manual, complete a CareLink NM application, and pass a readiness review process.

Staffing Requirements

Staffing requirements outline internal staff each provider agency must retain, what their qualifications must be, and for certain staff positions, how many individuals must be retained to meet staff to patient ratios requirements.

The following individuals and practitioners with the corresponding qualifications must be contracted or employed by the provider agency as part of its CareLink NM service delivery:

1. A ***Director*** who is specifically assigned to CareLink NM service oversight and administrative responsibilities.
2. A ***Health Promotion Coordinator*** with a bachelor's-level degree in a human or health services field and experience in developing curriculum and curriculum delivery. The health promotion coordinator manages health promotion services and resources appropriate for a CLNM Member such as interventions related to substance use prevention and cessation, nutritional counseling, or health weight management.
3. ***Care Coordinators***, who:
    a. Are regulation and licensing department (RLD) licensed behavioral health practitioners; or
    b. Hold a human services bachelor's level degree and have four years of experience; or
    c. Hold a human services master's level degree and have two years of experience.

    Care coordinators develop and oversee a CLNM Member's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services.

    The provider agency must employ enough care coordination staff to meet the ratio requirements established in the State Plan and meet the needs of the CLNM Members' receiving CareLink NM services.

4. A ***Community Liaison*** who is bilingual and speaks a language which is utilized by a majority of non-fluent English-speaking CLNM Members, and who is experienced with the resources in the CLNM Member's local community. The community liaison identifies, connects, and engages with community services, resources, and providers. The community liaison works with a CLNM Member's care coordinator in appropriately connecting and integrating the CLNM Member to needed community services, resources, and practitioners.
5. A ***Supervisor*** of the care coordinators, community liaison, and the physical health and psychiatric consultants, who is an independently licensed behavioral health practitioner as described in 8.321.2 NMAC. The supervisor must have direct service experience in working with both adult and child populations.
6. A ***Certified Peer Support Worker (CPSW)*** who holds certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker. The CPSW has successfully remediated his or her own behavioral health disorder, and is willing to assist his or her peers in their recovery processes.
7. A ***Physical Health Consultant*** who is a physician licensed to practice medicine (MD) or osteopathy (DO), a licensed certified nurse practitioner (CNP), or a licensed certified nurse specialist (CNS) as described in 8.310.3 NMAC.
8. A ***Psychiatric Consultant*** who is a physician (MD or DO) licensed by the Board of Medical Examiners or Board of Osteopathy and is board-eligible or board-certified in psychiatry as described in 8.321.2 NMAC.

A provider agency must also maintain the following care coordinator to CLNM Member ratios.

Care Coordination Level 3	1:50
Care Coordination Level 2	1:100

Individual caseloads for each care coordinator may vary based on the needs of individual CLNM Members and the distance from the practice a care coordinator must travel to serve the CLNM Members. The ratio requirements should be considered a maximum number of CLNM Members that can be assigned to a care coordinator as opposed to a standard.

For a provider agency that renders both physical health and behavioral health services on-site, additional staff may be included. Eligible providers that provide physical and behavioral health services to CLNM Members may include the following State licensed practitioners:

a. Behavioral health professionals or specialists;
b. Nurse care coordinators;
c. Nurses;

d. Medical specialists;
e. Physicians;
f. Physicians' Assistants;
g. Pharmacists;
h. Social Workers;
i. Licensed complementary and alternative medicine practitioners;
j. Dieticians; and
k. Nutritionists.

Data Requirements

The CareLink NM provider agency is responsible for collecting data that supports care integration, tracking of opt in/opt out affirmation, member authorized data sharing agreement information as well as assessments, CareLink NM Plans and information for a continuous quality improvement program. The data collected must be sufficient to fully inform ongoing quality measurement, an evaluation of coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. There are eight health home quality indicators mandated by CMS and included in HSD's state plan amendment (SPA) including:

1. Measure ABA-HH: Adult Body Mass Index (BMI) Assessment
2. Measure CDF-HH: Screening for Clinical Depression and Follow-Up Plan
3. Measure PCR-HH: Plan All-Cause Readmission Rate
4. Measure FUH-HH: Follow-Up After Hospitalization for Mental Illness
5. Measure CBP-HH: Controlling High Blood Pressure
6. Measure CTR-HH: Care Transition – Timely Transmission of Transition Record
7. Measure IET-HH: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
8. Measure PQI92-HH: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite

Additional indicators are being evaluated by the HSD quality work team and Steering Committee, and will be addressed at a later time.

Data collection and reporting require use of the web-based tool, BHSDStar, which will collect and record information regarding CareLink NM participants registration in CareLink NM, assessments, the CareLink NM Plan, referrals and call tracking, opt in/opt out affirmed status and data sharing agreement information. To support use of this and other web-based data tools, the provider agency must have computers with an internet connection.

Utilizing a combination of the Omnicaid (for FFS claims and encounter data) and BHSDStar (registry and tracking CareLink NM modules), the CareLink NM provider must utilize the following rules:

In BHSDStar:

1. A Medicaid recipient can be in CareLink NM if he/she is in FFS or in Managed Care;

2. A CLNM Member cannot be in more than one type of CareLink NM Health Home at the same time and cannot have more than one value for Care Coordination at the same time;
3. The MCO is not allowed to enroll a Medicaid recipient into CareLink NM, the CareLink NM provider will complete this task; and
4. If the CLNM Member enrolled into CareLink NM is in Centennial Care, Omnicaid will generate a file to the MCO to show the CLNM Member enrollment in CareLink NM. This is accomplished by generating a new interface with the MCOs.

In OMNICAID:
The Health Home level will be captured in the Care Coordination Level code field (either value 6 or 7). The Health Home Type will always be entered as value 'C' for CareLink NM and the Health Home Effective and End Dates on the incoming file from BHSDStar should also be used to fill in the Care Coordination Effective and End dates. There will be basic editing on the incoming file to ensure that the errors belowdo not occur. If these errors occur, it will cause the incoming record to be rejected and be reported back to BHSDStar on a "reject file" which has all the same elements of the incoming file plus the corresponding error message;

1. The CLNM Member Medicaid ID, Name and DOB don't match the client on Omnicaid; verify the client is correct in the same manner as used by the MCO for the HSD Interface file, by comparing last name and DOB. If either of these matches, then the client is considered to be verified. For the last name verification, the last name is only checked up to the first space. For example, if the Last Name field in Omnicaid contains 'SMITH JR', only 'SMITH' is used in the comparison. The birthday from the input file (CCYYMMDD) is reformatted and compared to the B_DOB_DT from Omnicaid. If neither of these fields match, an error condition exists and no subsequent errors will be done;
2. The CLNM Member on Omnicaid is not eligible for Medicaid for the dates of service on the incoming file;
3. The incoming Care Coordination Level is a value other than '6' or '7' (the only valid entries for the file from STAR);
4. The incoming Health Home Type is anything other than value 'C';
5. The client already has a CareLink NM Health Home entry with dates that overlap the incoming span;
6. The Health Home Effective date is prior to April 1, 2016 or is an invalid date or greater than the Health Home End Date;
7. The Health Home Provider NPI on the incoming file is not a valid NPI or the provider does not have the Health Home indicator checked or the provider is not active with status 60 or 70 for the dates on the incoming file;
8. The incoming Health Home span is for a CLNM Member for whom an existing open Health Home type 'A' or 'B' exists, error with the message that the client has existing Health Home value ' '; and

9. The incoming Health Home span is for a CLNM Member for whom an existing open Health Home type 'C' exists but with a different Health Home Provider and overlapping dates, error with the message that existing Health Home different provider exists.

The incoming file dates should be edited in the following way:

1. The incoming Health Home End Date can be open-ended;
2. If the CLNM Member already has a Care Coordination entry with a Value other than '6' or '7' that has an open-ended date, close the existing span one day prior to the effective date on the incoming CareLink span;
3. If the CLNM Member already has a Care Coordination entry with the same Value as on the incoming ('6' or '7') and the begin date is prior to the existing date for that Value and Provider ID is the same, update the begin date of the existing Health Home span; and
4. If the incoming contains a Health Home span end date for a CLNM Member with an existing open-ended span, this will cause that span to be end-dated.

For those CLNM Members who receive Medicaid services through the FFS system, the reporting and data exchange will occur directly with Omnicaid. For MCO Members', data exchange will be facilitated through the MCOs.

Reporting Requirements

Each provider will be responsible for providing reports to the State and/or to the MCO on CareLink NM activities and outcomes. The reporting requirements will be published in a later release of this manual.

Application Process

In order to enroll as a provider agency, the provider must complete an application which will be reviewed by HSD. The CareLink NM application consists of a request for information about the service provider, population served, some behavioral and physical health integration activities, screening and treatment service checklist, a provider and partner outreach and engagement plan, among other requests for information. The applicant must also agree to comply with all Medicaid program requirements. The application can be found at the following link: http://www.hsd.state.nm.us/uploads/files/Public%20Information/CareLink/CareLink%20NM%20Provider%20Agency%20Application%20Final.pdf.

After submitting the formal application, the Steering Committee will review content to ensure it is sufficient and meets the provider and service requirements. If approved, MAD will notify the applicant and will then conduct readiness review assessments.

Readiness Requirements

HSD, along with the Steering Committee, will conduct readiness reviews, consisting of pre and post-implementation assessments, with all selected applicants to evaluate their readiness to meet the service requirements of CareLink NM. The State will assess the indicators of program implementation from enrollment data, CLNM Member engagement,

claims/encounter data, CLNM Member assessment data and interim progress reports from the operating provider agency. This multidisciplinary team will include MAD staff and the single state authority (SSA) for mental health and substance use, the Behavioral Health Services Division (BHSD).

As HSD evaluates the outcomes of CareLink NM services and the current delivery system, additional qualifying chronic conditions or other changes to the program may be implemented. The State reserves the right to conduct additional readiness assessments based on program changes or additions over time.

Health Home Operations

Identifying Members

Individuals identified for enrollment in CareLink NM will meet the following criteria:

a) A Medicaid enrollee with full benefits, including FFS recipients or MCO Members, who are 21 years of age or older and meet the criteria for SMI; or
b) A Medicaid enrollee with full benefits, including FFS recipients or MCO Members, who are under 21 years of age who meets criteria for SED; and
c) Reside in an HSD approved county that has a designated Health Home provider in that county. For enrollment on April 1, 2016, these counties include Curry County and San Juan County.

The criteria for SMI and SED diagnosis can be found in Appendix C of this Policy Manual. Individuals eligible for enrollment in CareLink NM will be identified broadly by HSD, MCOs, the CareLink NM provider agency, community members, and hospital emergency departments (EDs). These processes are outlined in greater detail in the following Enrollment/Disenrollment section.

Enrollment/Disenrollment

Enrollment

FFS recipients and MCO Members who meet the eligibility criteria for the program will be automatically enrolled in CareLink NM if they have already engaged with the provider agency. Those who are eligible, but have not engaged with the provider agency, will be identified by the State, the MCO, or by referral by the local community.

For members enrolled in Centennial Care who are eligible for CareLink NM services, and have already engaged with a provider agency, the MCO and the CareLink NM provider will identify and contact these individuals for enrollment in CareLink NM. These eligible MCO Members will be automatically enrolled in CareLink NM and must affirmatively agree to opt into CareLink NM no later than 90 calendar days from notification of the automatic enrollment by signing an opt-in form and . For MCO Members who are eligible for CareLink NM services, but have not engaged directly with a provider agency, CareLink NM will work within the community to engage and enroll those eligible for services. Centennial Care Members may also be referred by the MCO when appropriate.

For Medicaid recipients enrolled in FFS Medicaid who are eligible for CareLink NM services and have already engaged with a provider agency, the provider agency will be responsible for identifying and contacting the individual for enrollment in CareLink NM. The provider agency will not automatically enroll these Medicaid recipients.

Medicaid recipients enrolled in FFS Medicaid, who are eligible for CareLink NM services, but have not engaged directly with a provider agency, may request enrollment in the CareLink NM program at a participating agency. Due to HIPAA restrictions, the FFS recipients that would be eligible by diagnosis will not be automatically enrolled, nor will their information be relayed to the provider agency. Instead, Medicaid recipients in Curry County and San Juan County will be contacted by the State with informational material encouraging enrollment in CareLink NM. Outreach by the State may consist of hardcopy materials mailed to the Medicaid recipient to assist in their enrollment in CareLink NM, including phone numbers and in-person enrollment locations.

Medicaid recipients may contact participating CareLink NM agencies, their assigned MCO, or HSD to determine if they are eligible for CareLink NM. Every CLNM Member also has the right to opt-out of participating in CareLink NM. CLNM Members can opt-out of participation in the CareLink services without losing Medicaid-covered services, or change enrollment to another CareLink provider within the same network at any time if desired.

A form documenting that CLNM Members have elected to affirmatively agree to opt into CareLink NM must be retained on file in order to receive reimbursement for delivery of CareLink NM services. The enrollment information can be entered in BHSDStar at any time, and will be automatically transmitted to the Omnicaid system and subsequently to the MCO daily; however, the effective date of enrollment can only be the first day of each month. It is the responsibility of the CareLink NM provider agency to communicate this information to the potential CLNM Member. If the delivery of services, including a diagnostic evaluation to determine eligibility, occurs before enrollment or before the first day of the month, the CareLink NM agency will bill the MCO or Xerox for each service rendered.

Information from MCO on Enrollment
In cases where the MCO is already providing services to the CLNM Member, the following information will be transferred from the MCO to the CareLink NM provider in paper or electronic format:

Documents
History & Physical
Individualized Service Plans
Health Risk Assessment
Comprehensive Needs Assessments

Documents
Functional Assessment
CareLink NM Plan
Emergency & Back-up Plan
Behavioral Health – Co-management Summary Notes
Client Contact Special Considerations
Care Coordination Plans for Clients with ISHCN
Advance Directive

Each MCO and CLNM provider should agree to timeframes and file formats individually.

Member Disenrollment
Every CLNM Member has the right to opt out of, or disenroll from CareLink NM at any time. A CLNM Member may disenroll from CareLink NM at any point after enrollment. Opting out or disenrolling from CareLink NM does not affect access to services for the individual with the exception of CareLink NM specific health home services offered only to participants in the health home program. A form documenting that Medicaid recipients have elected to opt out of CareLink NM must be retained on file and in BHSDStar.

To disenroll, the CLNM Member must contact his/her CareLink NM provider agency who will in turn disenroll them from the BHSDStar system. The BHSDStar system interface will transmit this information to Omnicaid, which will then transmit the same information to the pertinent MCO on a nightly basis. Disenrollment can be entered into the BHSDStar system at any time, but only become effective on the last day of any given month. It is the responsibility of the CareLink NM provider agency to communicate this information to the CLNM Member.

Program Disenrollment
Disenrollment can also occur when a CLNM Member no longer meets the program's eligibility criteria. This may occur because a CLNM Member moves out of an approved county, or loses Medicaid eligibility. A CLNM Member may or may not notify the provider agency or its provider network of this change. If this information is conveyed to the provider agency by the CLNM Member, the provider agency will notify the individual's assigned MCO enter in Omnicaid as soon as possible, but no later than the last day of the month, and disenroll that CLNM Member in the BHSDStar system.

Transition

Comprehensive transitional care is one of the six core CareLink NM services. Provider agencies are responsible for taking a lead role in transitional care activities including coordinating the CareLink NM Plan, reducing hospital admissions, coordinating the

transition to long-term services and supports and interrupting patterns of frequent hospital emergency department use. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care and from jails and detention facilities back to the community.

To facilitate transitions, provider agencies collaborate with physicians, nurses, social workers, discharge planners, pharmacists, community benefit providers and others to continue implementation of the CareLink NM Plan. There will be a specific focus on enhancing the CLNM Member and his/her family's ability to manage care and live safely in the community, and enhance the use of proactive health promotion and self-management. Each provider agency, in the application or through other means, will document a provider and partner outreach and engagement plan, which is the foundation for transitional care services.

Critical planning and transition documents will be available via web-based tools or they may be shared via secure email or hard copy. As outlined in the Health Information Technology section later in the Manual, the BHSDStar web-based data collection tools will be used to create HIT linkages for this project. These resources are intended to support transitional support needs of CLNM Members, among other functions.

Assessment

The provider agency is responsible for conducting the CareLink NM Needs Assessment for CLNM Members. The Needs Assessment determines needs related to the CLNM Member's physical and behavioral health, long-term care, community support resources and family supports. The provider agency should begin to reach out to the CLNM Member to schedule a Needs Assessment within fourteen (14) calendar days of the CareLink NM provider receiving a referral. The provider agency should work to complete the Needs Assessment within thirty (30) calendar days of a new CLNM Members enrollment. If the agency is utilizing the "treat first" model of care the individual should not be enrolled in CareLink NM until a pertinent diagnosis has been established. This may occur at any time from the first appointment through the fourth, but in all cases once enrollment has occurred. HSD recognizes that there are circumstances when timeframes for completing a Needs Assessment may not be met based on the individual circumstances for a Member. The CareLink NM provider must be able to produce evidence that it has met with the member and begun identifying and addressing primary physical and behavioral health needs within the required timeframes. The timeframes should serve as a benchmark for, at least, attempting to schedule and complete the Needs Assessment. When contact is made with the CLNM Member, the provider agency may begin treatment as knowledge of comprehensive needs and plans for treatment increases with each encounter. Both the Needs Assessment and the CareLink NM Plan will be updated as status changes, i.e. progress or lack of progress in recovery dictates, and the member, family and multi-disciplinary team determines necessary. The CareLink NM Needs Assessment can be found in Appendix A of this Manual.

The HRA shall determine whether an MCO Member requires care coordination level 1 or requires a comprehensive needs assessment (CNA) to determine whether the MCO Member should be assigned to care coordination level 2 or level 3. The care coordination level assignment, in turn, impacts the frequency of the recurring Needs Assessment. MCO Members with level 2 and 3 care coordination assignments are the only individuals who qualify for a CareLink NM referral in Centennial Care. However, it may be that an MCO care coordination level 1 individual has either not been reached, or has refused care coordination from the MCO. For those MCO members with the qualifying characteristic of SMI/SED that have a level 1 care coordination assignment due to the above reasons, the MCO will refer to the CareLink NM provider agency for contact, possible admission to CareLink NM and a new care coordination level assignment based upon an assessment by CareLink NM. As the CareLink NM Needs Assessment is completed, the CLNM Member's care coordination level assignment may change, which must be communicated through Omnicaid. Omnicaid will convert a care coordination level 2 to a level 6, and a level 3 to a level 7. These new numbers have all the same attributes as care coordination levels 2 and 3, but designate that the Member is enrolled in CLNM. This information will be transmitted via the nightly data exchange from Omnicaid to the pertinent MCO.

For Members with a level 6 care coordination assignment, a Needs Assessment will be completed at least annually. For Members with a level 7 care coordination assignment, a Needs Assessment will be completed at least semi-annually. Should there be significant changes in a Member's condition leading to increasing needs, the assessment timeframe will be expedited and service changes will be instituted within ten (10) calendar days of provider becoming aware of the change in the Member's condition and needs. For FFS recipients, the criteria below will be utilized by the CareLink NM provider agency to determine the appropriate care coordination level.

For MCO Members who have not had an HRA completed and for FFS Members, the provider agency is to use appropriate clinical judgment in meeting the needs of the CLNM Member in assigning the relevant level of care. Each Member should be assigned a Care Coordination level based on his/her individual needs. The following guidance for level of care determinations should be utilized:

<u>Requirements for Care Coordination Level 6</u>
Based on the CareLink NM needs assessment, the CareLink NM provider shall assign care coordination level 6, at a minimum, to Members with one of the following:

- Co-morbid health conditions;
- Frequent emergency room use (as defined by the CareLink NM provider);
- A mental health condition causing moderate functional impairment;
- Requiring assistance with two (2) or more ADLs or IADLs living in the community at low risk;
- Mild cognitive deficits requiring prompting or cues; and/or
- Poly-pharmaceutical use.

<u>Requirements for Care Coordination Level 7</u>

Based on the comprehensive needs assessment, the CareLink NM provider shall assign care coordination level 7, at a minimum, to Members with one the following:

- Who are medically complex or fragile;
- With excessive emergency room use (as defined by the CareLink NM Provider);
- With a mental health condition causing high functional impairment;
- With untreated comorbid substance dependency based on the current DSM or other functional scale determined by the State;
- Requiring assistance with two (2) ADLs or IADLs living in the community at medium to high risk;
- With significant cognitive deficits; and/or
- With contraindicated pharmaceutical use.

The initial Needs Assessment may be performed face-to-face with the CLNM Member in his/her home. The home is defined as the primary residence of the CLNM Member in the community. If the CLNM Member is homeless, the Needs Assessment may be conducted at a location mutually agreed upon by the CLNM Member, HSD and CareLink NM coordinator. If the relationship with the CLNM Member has not progressed to the level that the Member is comfortable, the visit in the home may be postponed and the assessment initiated in another mutually agreed upon location. In all cases the following rules apply:

- A face-to-face visit must occur in the home within six months of engagement. If after six months, there has been a good faith effort to conduct an in-home, face-to-face visit, and it does not occur, the provider will notify the Quality Bureau at, HSD-QB-CCU-CNA@state.nm.us, to request a Needs Assessment exception;
- A face-to-face visit must occur within two weeks of a nursing facility level of care determination;
- A face-to-face visit must occur to address health and safety concerns or other related reasons;
- Alternate locations should be assessed for CLNM Member privacy to ensure protected health information (PHI) is not compromised; and
- Each CareLink NM provider must use the Needs Assessment tool provided by HSD.

Care Planning

The provider agency completes a CareLink NM Plan approved by HSD, with active participation of the CLNM Member, their family and/or his or her authorized representative. The provider agency also consults with the CLNM Member's primary care provider, specialists, behavioral health providers, community benefit providers (if applicable), other providers, and interdisciplinary team experts, as needed in the development of the CareLink NM Plan.

The CareLink NM Plan maps a CLNM Member's path towards self-management of his/her condition, and is specifically designed to meet all of his/her physical health, behavioral health, long-term care and social health needs. The CareLink NM Plan also reflects goals of the CLNM Member to foster self-management.

The CareLink NM Plan is a document that must be revised over time to consistently address identified needs, communicate the services a member should be receiving and serve as a shared plan for the member, their family and/or representatives and service providers. As such, the CareLink NM Plan must be provided to the member and their providers. The CareLink NM provider must ensure there is evidence of reviews and updates to the CareLink NM Plan with appropriate frequency to meet the CLNM Member's needs.

For consistency among all providers engaged with CareLink NM, each CareLink NM provider must use the CareLink NM Plan provided by HSD. The CareLink NM Plan can be found in Appendix B of the Manual.

Back-Up and Crisis/Emergency Plans

Each CareLink NM Plan includes a back-up and crisis/emergency plan that is developed with the CLNM Member. The back-up plan is intended primarily for CLNM Members receiving Home and Community-Based Services (HCBS) and should address situations when regularly scheduled providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts. The Crisis/Emergency Plan should list any steps the CLNM Member and/or a Representative should take in the event of an emergency that differ from the standard emergency protocol.

Treatment Plan

In most cases the CareLink NM Plan will be supplemented by treatment plans that are developed by direct practitioners. These plans are different as they are a more detailed accounting of the identified treatment that the CLNM Member will receive. These treatment plans for either physical or behavioral health needs should be reviewed by the Care Coordinator and maintained in the CLNM Member's file. Under no circumstances will the care coordinator, who develops the CareLink NM Plan, develop any treatment plans.

Health Promotion

The provider agency is to use consumer-level, clinical data to address health promotion programming for a CLNM Member's specific health promotion, self-monitoring and self-care needs and goals (e.g., working with a CLNM Member on his or her individual health promotion goals). To carry out these objectives, the provider agency is to develop systematic strategies to address health promotion for CLNM Members through programs or initiatives. This should include using evidence-based, evidence-informed, best, emerging and/or promising practices related to smoking cessation, nutrition, or chronic disease management.

The programs or initiatives designed to meet the health promotion objectives may include classes or counseling. Health promotion activities are provided on a group or individual basis. The curriculum for the programs or initiatives will be reviewed and approved by the Steering Committee to ensure it meets the needs of the population served and is innovative, measurable and integrates physical and behavioral health concepts.

The provider agency tracks the success of adopted health promotion strategies, as well as identifies areas of improvement for the programs. Areas identified for improvement will inform health promotion curriculum changes where necessary. Tracking activities should also influence the use of various health promotion activities recommended to CLNM Members. If, for example, tracking finds that group smoking cessation classes are having a much more successful impact on those enrolled than one-on-one counseling sessions, CLNM Members should be encouraged to enroll in group classes, and class frequency should be expanded to accommodate more participants. The Steering Committee will work with the provider agency on a reporting schedule of ongoing health promotion and tracking activities.

Accessibility to CareLink NM Members—Hours of Operation

Each CareLink NM Provider should have a plan for providing necessary care coordination services outside of regular business hours (9:00 AM – to 5:00 PM). Each CareLink NM provider must comply with Section 8.321.2 of New Mexico Administrative Code (NMAC) which states that a specialized behavioral health provider "must maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the MAP eligible recipient, make referrals' as necessary and provide follow-up to the MAP eligible recipient. The CLNM Members should be provided with information about how to reach their Care Coordinator or another qualified member of the CareLink NM team in an emergency situation that may occur evenings or weekends.

HIPAA

The provider agency must comply with applicable provisions of the federal Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191). This includes, but is not limited to, the requirement that the provider agency's management information system (MIS) complies with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA. The provider agency must also comply with HIPAA electronic data interchange (EDI) requirements and notification requirements, including those set forth in the federal Health Information Technology for Economic and Clinical Health Act (HITECH Act, P.L. 111-5).

The provider agency must notify the MCO and HSD of all breaches or potential breaches of unspecified PHI, as defined by the HITECH Act, without unreasonable delay and in no event later than thirty (30) calendar days after discovery of the breach or potential breach. If, in HSD's determination, the CareLink NM provider has not provided notice in the manner or format prescribed by the HITECH Act, then HSD may require the CareLink NM provider to provide such notice.

Disclosure and Confidentiality of Information

Confidentiality

The provider agency, its employees, agents, consultants or advisors must treat all information that is obtained through a CLNM provider's delivery of the services including, but not limited to, information relating to CLNM Members, potential recipients of HSD and

the associated providers, as confidential information to the extent that confidential treatment is provided under State and federal law, rules, and regulations.

The provider agency is responsible for understanding the degree to which information obtained through the performance of this service is confidential under State and federal law, rules, and regulations.

The provider agency and all consultants, advisors or agents shall not use any information obtained through performance of this service in any manner except as is necessary for the proper discharge of obligations and securing of rights under this service.

Within sixty (60) calendar days of the effective date of service implementation, the provider agency shall develop and provide to the CareLink NM Steering Committee for review and approval, written policies and procedures for the protection of all records and all other documents deemed confidential.

Any disclosure or transfer of confidential information by the provider agency will be in accordance with applicable law. If the provider agency receives a request for information deemed confidential under this Agreement, the provider agency will immediately notify the MCO or MAD of such request, and will make reasonable efforts to protect the information from public disclosure.

In addition to the requirements expressly stated in this Section, the provider agency must comply with any policy, rule, or reasonable requirement of HSD that relates to the safeguarding or disclosure of information associated with CLNM Members, the provider agency's operations, or the provider agency's performance of this service.

In the event of the expiration of this service or termination thereof for any reason, all confidential information disclosed to and all copies thereof made by the provider must be returned to HSD or, at HSD's option, erased or destroyed. The provider agency must provide HSD with certificates evidencing such destruction.

The provider agency's contracts with practitioners and other providers shall explicitly state expectations about the confidentiality of HSD's confidential information and CLNM Member records.

The provider agency shall afford CLNM Members and/or Representatives the opportunity to approve or deny the release of identifiable personal information by the provider agency to a person or entity outside of the provider, except to duly authorized providers or review organizations, or when such release is required by law, regulation or quality standards.

The obligations of this Section must not restrict any disclosure by the provider pursuant to any applicable law, or under any court or government agency, provided that the provider must give prompt notice to HSD of such order.

Disclosure of HSD's Confidential Information

The provider will immediately report to HSD and MCOs as appropriate, any, and all unauthorized disclosures or uses of confidential information of which it or its consultants, or agents is aware or has knowledge. The provider acknowledges that any publication or disclosure of confidential information to others may cause immediate and irreparable harm to HSD and may constitute a violation of State or federal statutes. If the provider, its consultants, or agents should publish or disclose confidential information to others without authorization, HSD will immediately be entitled to injunctive relief or any other remedies to which it is entitled under law or equity. HSD will have the right to recover from the provider all damages and liabilities caused by or arising from the provider's, its representatives', consultants', or agents' failure to protect confidential information. The provider will defend with counsel approved by HSD, indemnify and hold harmless HSD from all damages, costs, liabilities, and expenses caused by or arising from the providers', representatives', consultants' or agents' failure to protect confidential information. HSD will not unreasonably withhold approval of counsel selected by the CareLink NM Health Home.

The provider will require its consultants, and agents to comply with the terms of this Section.

Member Records
The provider must comply with the requirements of State and federal statutes, including the HIPAA requirements set forth in this Agreement, regarding the transfer of CLNM Member records.

The provider shall have an appropriate system in effect to protect substance abuse CLNM Member records from inappropriate disclosure in accordance with 42 U.S.C. § 300x-53(b), and 45 C.F.R. § 96.13(e).

If this Agreement is terminated, HSD may require the transfer of CLNM Member records, upon written notice to the provider, to another entity, as consistent with federal and State statutes and applicable releases.

The term "Member record" for this Section means only those administrative, enrollment, case management and other such records maintained by the provider and is not intended to include patient records maintained by participating Contract providers.

Requests for Public Information
When the provider produces reports or other forms of information that the provider believes consist of proprietary or otherwise confidential information, the provider must clearly mark such information as confidential information or provide written notice to HSD that it considers the information confidential.

If HSD receives a request, filed in accordance with the New Mexico Inspection of Public Records Act (IPRA), NMSA 1978, 14-2-1 et seq. seeking information that has been identified by the provider as proprietary or otherwise confidential, HSD will deliver a copy of the IPRA request to the provider.

Unauthorized Acts
Each Party agrees to:

- Notify the other Parties promptly of any unauthorized possession, use, or knowledge, or attempt thereof, by any person or entity that may become known to it, of any confidential information or any information identified as confidential or proprietary;
- Promptly furnish to the other parties full details of the unauthorized possession, use, or knowledge, or attempt thereof, and use reasonable efforts to assist the other Parties in investigating or preventing the reoccurrence of any unauthorized possession, use, or knowledge, or attempt thereof, of confidential information;
- Cooperate with the other parties in any litigation and investigation against third parties deemed necessary by such party to protect its proprietary rights; and
- Promptly prevent a recurrence of any such unauthorized possession, use, or knowledge of such information.

Information Security
CareLink NM and all its consultants, representatives, providers and agents must comply with all applicable statutes, rules, and regulations regarding information security, including without limitation the following Centennial Care Agreement Requirements:

7.26.6.1.1 Health and Human Services Enterprise Information Security Standards and Guidelines;
7.26.6.1.2 HIPAA;
7.26.6.1.3 HITECH Act; and
7.26.6.1.4 NMAC 1.12.20 et seq.

Referrals and Communication

The provider agency is required to meet the integrated physical, behavioral, and long term health needs of its CLNM Members by partnering with physical and behavioral health providers, support service agencies, and long-term care providers. This will require referral and communication protocols, which in some instances, are to be outlined in MOAs. MOAs are required for at least one primary care practice in the area that serves CLNM Members under 21 years of age, at least one primary care practice that serves CLNM Members 21 years of age and older, with hospitals, and with residential treatment facilities. MOAs are not required for support services agencies such as food banks. The referral and communication protocols must be submitted to the Steering Committee for review as part of the application or readiness review process or through other means.

There are different expectations of referral and communication protocols where MOAs are and are not required. For partnerships that require MOAs, the referral process must include acknowledgment of recipient of the referral and follow-up with the CLNM Member. Once a referral is made, the health care provider also has access to relevant data on the

CLNM Member, including his or her CareLink NM Plan, unless the member does not authorize such data exchange.

For example, if a CLNM Member is referred for follow-up primary care, the provider agency will work with the CLNM Member and its partner primary care office to schedule the follow-up care. Once the referral has been finalized, the primary care office will then have access to relevant health data on the CLNM Member and will provide necessary follow-up care. After care is scheduled to occur, the provider agency will confirm that the appointment did take place and check on outstanding care or treatment issues that were brought to light during the appointment. As part of the provider agency's reporting requirements, the communication loop of referrals and follow-up will be tracked.

For partnerships where MOAs are not required, there should be a good faith effort by the provider agency to ensure that the support services are delivered. The provider agency must identify available community-based resources and actively manage appropriate referrals and access to care, engagement with other community and social supports, and follow-up post-engagement. Common linkages include continuation of health care benefits eligibility, disability benefits, housing, legal services, educational supports; employment supports, and other personal needs consistent with recovery goals and the CareLink NM Plan. The care provider or care coordinator will make referrals to community services, link clients with natural supports and assure that these connections are solid and effective. The care coordinators are responsible for documenting the outcome of the referral including noting that the Member and/or Provider followed up and any additional recommendations resulting from the referral.

Grievances and Appeals

CareLink NM Care Coordinators will be responsible for assisting CLNM Members with appeals and grievances, including, but not limited to reporting member grievances and explaining the right of appeal process to members. Communication will need to be established with the member's MCO and/or HSD for instructions on how to file grievance paperwork, how to file an appeal including applicable timeframes, and what department to contact with grievance and appeals issues.

Critical Incident Reporting

All providers rendering Medicaid funded services to the HCBS population, including CareLink NM provider agencies, are required to report critical incidents. The MCO is required to research and investigate the critical incident and must be informed of its occurrence. New Mexico State statutes and regulations define the expectations and legal requirements for properly reporting recipient involved incidents in a timely and accurate manner. The CareLink NM provider agency is responsible for understanding and complying with these requirements.

To assist CareLink NM provider agencies in understanding and complying with critical incidence reporting, the "Critical Incident Management Guide and Critical Incident Training Guide" is available at the following address: https://criticalincident.hsd.state.nm.us/Default.aspx. For questions about obtaining

passwords and access to the reporting portal, email the HSD Critical Incident team at: HSD-QB-CIR@state.nm.us

MCO Role

The MCO will serve a complimentary, but not duplicative, role in the delivery of CareLink NM services. The MCO role begins with identifying and contacting their Members who meet the eligibility criteria and have engaged with the provider entity for enrollment in CareLink NM. The MCO may also refer Members for CareLink NM enrollment who are otherwise eligible, but have not engaged with a provider agency. In addition, MCOs have the following responsibilities:

- Conducting Member initial HRAs including initial recommendation and referral to the CareLink NM provider of care coordination levels, which in turn informs the staffing ratios for the provider agency;
- Conducting the Nursing Facility Level of Care (NFLOC) and providing results to the CareLink NM provider;
- Processing of prior authorization requests from the CareLink NM provider;
- Processing and oversight of all CLNM Member claims and/or encounter data; and
- Establishing per member per month (PMPM) payment agreement on the pass-through of care coordination reimbursements from the State to the provider agency.

Emergency Department Referrals

Provider agencies are responsible for taking a lead role in transitional care activities including the interruption of patterns of frequent hospital emergency department (ED) use by CLNM Members. Provider agencies will work with health care providers and CLNM Members to support proactive health promotion and self-management, and ultimately, to prevent non-emergent use of the ED. To monitor success of preventing non-emergent use of the ED, data on hospital ED use by CLNM Members will be collected and reviewed by HSD and CMS. When a CLNM Member uses services in the ED, participating hospitals are required to refer them to provider agencies. This is a requirement of Section 2703 of the ACA. ED referral protocols should be established in MOAs with hospitals in the geographic vicinity.

Nursing Facility Level of Care (NFLOC)

In some cases, the CareLink NM Provider may have CLNM Members who also meet a NFLOC. For CLNM Members who have indicators for community-based long-term services and supports, the CareLink NM Care Coordinator must ask the CLNM Member if they wish to be evaluated for an NFLOC. The MCO will identify triggers that would indicate a Member may be eligible for NFLOC. If the CLNM Member is interested in an NFLOC evaluation, the CareLink NM Care Coordinator shall arrange for the evaluation with the assigned MCO. The CLNM care coordinator must accompany the MCO care coordinator to the appointment with the Member. If an FFS recipient is in need of an NFLOC assessment for long-term services and supports, the State requires that the Member must enroll with an MCO.

The MCO will be responsible for completing an NFLOC Assessment for those CLNM Members who qualify for Community Benefit Services. The MCO will also be responsible for

completing the allocation tool, which is used to determine how many hours of personal care services a CLNM Member receives and develop the community benefit care plan. The NFLOC and care plan will be provided to the CareLink NM provider agency for coordination and monitoring of utilization of the Community Benefit Services. An NFLOC reassessment must be conducted (by the MCO) at least annually. In addition, an NFLOC reassessment must be conducted within five (5) business days of becoming aware of a change in the CLNM Member's functional or medical status. The CareLink NM care coordinator is responsible for tracking these dates and ensuring communication regarding the CLNM Member's needs.

CLNM Members who meet the NFLOC have access to community-based long-term services and supports including:

- Community Benefits, as determined appropriate based on the Needs Assessment.
- CLNM Members eligible for the Community Benefit will have the option to select either the Agency-Based Community Benefit or the Self-Directed Community Benefit.
- CLNM Members selecting the Agency-Based Community Benefit will have a choice of the consumer delegated model or consumer directed model for personal care services.

The CareLink NM Care Coordinator must be familiar with these benefits and ensure the CLNM Member's choices are reflected in the CareLink NM Plan.

Health Information Technology

The BHSDStar web-based data collection tool is used to create HIT linkages for the provider agencies and ancillary care providers. BHSDStar is intended to provide information on CLNM Member registration, care coordination including call tracking and referrals, Needs Assessments, the CareLink NM Plan, and quality tracking. These resources will be available for minimal additional cost to the State and no cost to the provider in order to support the CareLink NM providers and the Care Coordinator to collect and store data, record any identified unmet needs, gaps in care, or transitional support needs.

In addition to these HIT linkages, HSD will begin using Medicaid Management Information System (MMIS) data elements already in place for the purpose of Health Home enrollment and plans to move the collected information to its OMNICAID Data warehouse for use in its analytics and evaluation.

The provider agency will be responsible for using HIT to link services, as feasible and where appropriate. The Needs Assessments, CareLink NM Plan, critical planning and transition documents and MCO or FFS utilization information will be available via web-based tools or they may be shared via secure data exchange, email or hard copy.

To support use of BHSDStar and other web-based data tools, the provider agency must have computers and an internet connection.

Registration –See Data Requirements Section

Client Services Module
This is a BHSDStar module for all the care coordination activities. It is currently being customized for CareLink NM with the help of provider organizations so that is reflects the way care coordination activities will be rendered.

Comprehensive Needs Assessment (CNA)
This is the standardized CareLink NM Needs Assessment which has been automated by BHSDStar, and will have varying levels of security (called permissions) reflective of which providers within the CareLink NM, may have access to the information. Access is based on the status of the relationship (MOA in place) and the Member's consent.

CareLink NM Plan
This is the standardized plan of care developed by HSD and the MCOs which will be utilized by all CareLink NM health homes, and automated by BHSDStar. It will have varying levels of security (called permissions) reflective of which providers within CareLink NM, may have access to the information. Access is based on the status of the relationship (MOA in place) and the Member's consent.

Quality
The provider agency is responsible for collecting data that supports a continuous quality improvement program. The data collected must be sufficient to fully inform ongoing quality measurement, an evaluation of coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. There are eight quality indicators mandated by CMS and included in HSD's SPA. Additional indicators are being evaluated by the quality work team and Steering Committee, and will be addressed at a later time. This module will be the last to be delivered.

Meaningful Use
A core service of the CareLink NM program is the use of HIT to link services for CLNM Members. To facilitate use of HIT, meaningful use practices defined by the Office of the National Coordinator (ONC), are to be adopted. Meaningful use, defined by ONC, is the use of certified electronic health record (EHR) technology to:

- Improve quality, safety, efficiency, and reduce health disparities;
- Engage patients and families;
- Improve care coordination, and population and public health; and
- Maintain privacy and security of patient health information.

Provider agencies will adopt meaningful use of HIT to help achieve the following goals:

- To improve clinical outcomes;
- To improve population health outcomes;
- To increase transparency and efficiency;
- To empower individuals; and
- To improve research data on health systems.

Health Home Reimbursement

PMPM

CareLink NM providers are reimbursed through a per-member per-month (PMPM) payment methodology. CareLink NM dedicated services include the six core service categories that are not duplicative of Centennial Care services. A CareLink NM provider agency will bill for the approved list of CareLink NM core services using the CMS 1500. Additional Medicaid covered services provided to a CLNM Member are billed and reimbursed separately from the approved list of CLMN core services.

The PMPM rate will be updated annually based upon analysis, including claims experience. HSD reserves the right to update the PMPM rate at times other than those identified in the manual. The PMPM reimbursement is paid for each CLNM Member, regardless of whether the CLNM Member is enrolled in an MCO or in FFS Medicaid. The CareLink NM provider agency is responsible for verifying that the CLNM Members have affirmatively agreed to participate and have opted into CareLink NM services, documentation of which is a signed statement in the CLNM Member's file, in order to receive reimbursement.

The codes for the CareLink NM approved services are listed below. Each month, the G9001code and one or more of the six CareLink NM core services listed must be rendered and claimed in order to receive a PMPM payment for that month.

CareLink NM Health Care Common Procedure Coding System (HCPCS) codes

Code	Modifier	CareLink NM Code Description	Units
S0280		**Comprehensive Care Management (CCM)** The identification of high risk individuals ensuring the individual and family are active participants in comprehensive service planning. Monitoring of the implementation of the CareLink NM Plan and 1) its evolution into individual health status and self-management, 2) utilization of services, and 3) prioritization of transitional care activities. Assigns "ownership" of an individual's care to the appropriate CareLink NM team.	15 minutes

Code	Modifier	CareLink NM Code Description	Units
T1016	**U1**	**Care Coordination (CC) & Health Promotion (HP)** **CC:** An assigned team lead coordinates the team, both in-house and with local community providers, in the development and implementation of the CareLink NM Plan. Reinforces treatment strategies that increase the individual's motivation to actively self-manage his or her chronic health conditions. **HP:** Individual, group and environmental strategies aimed at disseminating information regarding healthy living and ways to improve overall health and reduce the health consequences associated with chronic conditions such as substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.	15 minutes
T1016	**U2**	**Comprehensive Transitional Care** Maximizing the ability of the individual to live safely in the community and minimizing the utilization of out-of-home placement and hospital emergency departments. Assuring the continuation of the treatment plan across all levels of care such as early discharge planning and proactive prevention of avoidable readmissions. Requires effective point-of-service exchange of information including medication reconciliation and access.	15 minutes
T1016	**U3**	**Individual and Family Support** Assisting the individual in attainment of the highest level of health and functioning within the family and in broader community contexts. Individual engagements support recovery and resiliency, and may involve peer and family supports, targeted support groups, and formal self-care programs.	15 minutes

Code	Modifier	CareLink NM Code Description	Units
T1016	**U4**	**Referral to Community and Social Support Services** The identification of available community-based resources and the active management of appropriate referrals. Engagement with other community and social supports, and follow up post-engagement. Example linkages are disability benefits, housing, legal services, and other personal needs consistent with recovery goals and treatment plans.	15 minutes
T1016	**U5**	**Services linked through health information technology** The communication with team providers and referrals through information technology, and the updating of quality indicators and other prescribed information.	15 minutes
G9001		**Coordinated care fee, initial rate** This code must be billed one time for every month, in conjunction with a CareLink NM core services code.	**Capitation PMPM ***

Enrolling or Disenrolling an Individual as a CareLink NM Member in BHSDStar

The data elements that will be required and communicated from BHSDStar via interface to Omnicaid are:

- Client_SystemID (This is automatically recorded when entering the Medicaid ID)
- Client_Hlth_Home_Effective date_Date (the beginning of a month only)
- Client_Hlth_Home_End_Dt (12/31/9999 until they are being disenrolled)
- Client_Hlth_Home_Prov_NPI
- Client_Hlth_Home_Care Coordination Level_Cd (6 or 7)
- Client_Rec_Add_Medicaid ID (This is automatically recorded based on the CareLink NM user's security code when signing on.)
- Client_Rec_Add_Date (This is automatically recorded as the date you are entering the new information)
- Client_Rec_Add_Time (This is automatically recorded as the time you are entering the new information)
- Client_Rec_Update_User_ID (Enter the client Medicaid ID if you are updating a record, such as a new care coordination level, or disenrollment)
- Client_Rec_Update_Date (The date you are entering)
- Client_Rec_Update_Time (The time you are entering)

Non-Compliant Members

In accordance with the Centennial Care contract policy, provider agencies participating in CareLink NM must follow the same criteria as the MCOs prior to disenrolling a CLNM Member that has been noncompliant with his/her treatment as a result of being unreachable. If a CLNM Member is unable or unwilling to engage, the CareLink NM provider shall send a letter to the CLNM Member's most recently reported address to provide information about CareLink NM and how to contact the care team. Documentation of attempts to reach and engage the Member shall be included in the CLNM Member file.

Quality & Outcomes

Quality and health outcome measurement of CLNM Members are important for many reasons. Quality and health outcome measurement is a federal requirement of the Health Home program. It also provides essential information to the State and eligible providers on program impact to support the underlying goal of improving health, wellbeing and self-management of chronic conditions.

A set of core health measurements will be monitored by HSD to evaluate health outcomes of CLNM Members. The following table should serve as a guide on specific health performance measures that will be required for monitoring, as well as how and when these measures are to be reported. The table outlines core performance measures, data indicators on the core measures, whether the data is recorded as a process or health outcome, and frequency of data collection, quality, module entry, and measurement source. For quarterly reports outlined below, the following should serve as a timeline reference: Quarter 1, January-March; Quarter 2, January-June; Quarter 3, January-September; and Quarter 4, January-December.

Health Home Performance Measure	Data	Process/ Outcome	Reporting Frequency	Source
1. Adult body mass index (BMI) assessment	BMI Value	Process and Outcome	Quarterly	EHR
2. Screening for clinical depression and follow-up plan	Y/N	Process	Quarterly	CareLink NM Plan
3. Plan – all Cause readmission rate	Y/N	Outcome	Quarterly	Report from data warehouse using same diagnoses as original admission
4. Follow-up after hospitalization for mental illness	Y/N	Process	Quarterly	CareLink NM Plan
5. Controlling high blood pressure	Value	Outcome	Quarterly	EHR
6. Care Transition – timely transmission of transition record	Y/N	Process	Quarterly	Referral log

Health Home Performance Measure	Data	Process/ Outcome	Reporting Frequency	Source
7. Initiation and engagement of alcohol and other drug dependence treatment	Y/N	Process	Quarterly	CareLink NM Plan
8. Sensitive condition admission – (hospital admission of individuals under age 75 for angina, asthma, chronic obstructive pulmonary disease [COPD], diabetes, grand mal status and other epileptic convulsions, heart failure and pulmonary edema, hypertension)	Y/N	Outcome	Quarterly	Report from data warehouse

In the future, additional core health measurements will be added to this list and monitored by HSD to evaluate health outcomes of CLNM Members.

Health Home Forms

Appendix A—CareLink NM Needs Assessment

Appendix B—CareLink NM Plan

Appendix C—SMI/SED Definitions

Serious Mental Illness (SMI)
CRITERIA CHECKLIST

SMI determination is based on the age of the individual, functional impairment, duration of the disorder and the diagnosis. Adults must meet all of the following four criteria:

☐ 1. **Age:** Must be an adult 18 years of age or older.

☐ 2. **Diagnoses:** Have one of the diagnoses specified in the list below as defined under the current *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.* The diagnosis would need to have been determined within the prior 12 months by an appropriately credentialed and licensed professional.

☐ 3. **Functional Impairment:** The disturbance is excessive and causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

☐ 4. **Duration:** Expected duration of the disorder is to be six months or longer.

List of Diagnoses for #2 Above

Schizophrenia – 295.90 diagnoses

☐ Schizophrenia 295.90

Other Psychotic Disorders

☐ Delusional Disorder 297.1

☐ Schizoaffective Disorder 295.70

☐ Other Specified Schizophrenia Spectrum and Other Psychotic Disorder 298.8

☐ Unspecified Schizophrenia Spectrum and Other Psychotic Disorder 298.9

Major Depression and Bipolar Disorder

☐ Major Depressive Disorder 296.XX

☐ Bi-Polar Disorders 296.XX (all except Unspecified Bi-Polar and Related Disorder 296.80)

Other mood Disorders

☐ Cyclothymic Disorder 301.13

☐ Persistent Depressive Disorder 300.4

continued on next page

Anxiety Disorders

- ☐ Panic Disorder 300.01
- ☐ Generalized Anxiety Disorder 300.02

Obsessive Compulsive & Related Disorders

- ☐ Obsessive Compulsive & Related Disorders 300.3

Trauma and Stressor-Related Disorders

- ☐ Posttraumatic Stress Disorder 309.81

Eating Disorders

- ☐ Anorexia Nervosa 307.1
- ☐ Bulimia Nervosa or Binge Eating Disorder 307.51

Somatic Symptom and Related Disorders

- ☐ Conversion Disorder 300.11
- ☐ Somatic symptom Disorder 300.82
- ☐ Factitious Disorder Imposed on Self 300.19
- ☐ Borderline Personality Disorder 301.83

Dissociative Disorders

- ☐ Dissociative Amnesia 300.12
- ☐ Dissociative Identify Disorder 300.14

Personality Disorders [For which there is an evidence based clinical intervention available]

continued on next page

Person must meet SMI criteria and at least one of the following in A or B:

A. Symptom Severity and Other Risk Factors

- ☐ Significant current danger to self or others or presence of active symptoms of a SMI.
- ☐ Three or more emergency room visits or at least one psychiatric hospitalization within the last year.
- ☐ Individuals with substance use disorder that complicates SMI and results in worsened intoxicated/withdrawal complications, bio medical conditions, emotional/behavior/cognitive conditions.
- ☐ Person is experiencing trauma symptoms related to sexual assault, domestic violence or other traumatic event.

B. Co-Occurring Disorders

- ☐ Substance Use Disorder diagnosis and any mental illness that affects functionality.
- ☐ SMI or Substance Use Disorder and potentially life-threatening medical condition (e.g., diabetes, HIV/AIDS, hepatitis).
- ☐ SMI or Substance Use Disorder and Developmental Disability.

Severe Emotional Disturbance (SED)
CRITERIA CHECKLIST

SED determination is based on the age of the individual, diagnoses, functional impairment or symptoms, and duration of the disorder. The child/adolescent must meet all of the following criteria:

☐ 1. **Age:**

- ☐ be a person under the age of 18;

  OR

- ☐ be a person between the ages of 18 and 21, who received services prior to the 18th birthday, was diagnosed with a SED, and demonstrates a continued need for services.

☐ 2. **Diagnoses:**

Must meet A *or* B.

- ☐ **A.** The child/adolescent has an emotional and/or behavioral disability that has been diagnosed through the classification system in the current *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* In addition, please note the following:

  - Diagnoses that are included are only those providing a primary reason for receiving public system behavioral health services.

  - ☐ **Neurodevelopmental Disorders** – 299.00, 307.22, 307.23, 307.3, 307.9, 314.00, 314.01, 315.4, 315.35, 315.39, 315.8, 315.9, 319
  - ☐ **Schizophrenia Spectrum and other Psychotic Disorders** – 293.81, 293.82, 295.40, 295.70, 295.90, 297.1, 298.8, 293.89, 298.8, 301.22,
  - ☐ **Bipolar and Related Disorders** – 293.83, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.89
  - ☐ **Depressive Disorders** – 296.99, 293.83, 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36, 300.4, 31, 625.4
  - ☐ **Anxiety Disorders** – 293.84, 300.00, 300.01, 300.02, 300.09, 300.22, 300.23, 300.29, 309.21, 300.23
  - ☐ **Obsessive-Compulsive Related Disorders** – 294.8, 300.3, 300.7, 312.39, 698.4,
  - ☐ **Trauma-and Stressor Related Disorders** – 308.3, 309.0, 309.24, 309.28, 309.3, 309.4, 309.81, 309.89, 309.9, 313.89
  - ☐ **Dissociative Disorders** – 300.12, 300.13, 300.14, 300.15, 300.6
  - ☐ **Somatic Symptom and Related Disorders** – 300.11, 300.19, 300.7, 300.82, 300.89,
  - ☐ **Feeding and Eating Disorders** – 307.1, 307.50, 307.51, 307.52, 307.53, 307.59
  - ☐ **Elimination Disorders** – 307.6, 307.7, 787.60, 788.30, 788.39
  - ☐ **Disruptive, Impulse Control and Conduct Disorders** – 312.32, 312.33, 312.34, 312.81, 312.89, 312.9, 313.81
  - ☐ **Substance-Related and Addictive Disorders** – 292.9, 303.90, 304.00, 304.20, 304.30, 304.40, 304.50, 304.60, 304.90

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☐ **B.** The term "complex trauma" describes children's exposure to multiple or prolonged traumatic events, which are often invasive and interpersonal in nature. Complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse. *[Dear State Director letter, July 11, 2013, from CMS, SAMHSA, ACF.]* In order to qualify as a complex trauma diagnosis the child must have experienced one of the following traumatic events:

- ☐ Abandoned or neglected;
- ☐ Sexually abused;
- ☐ Sexually exploited;
- ☐ Physically abused;
- ☐ Emotionally abused; or
- ☐ Repeated exposure to domestic violence.

In addition to one of the qualifying traumatic events above, there must also be an exparte order issued by the children's court or the district court which includes a sworn written statement of facts showing probable cause exists to believe that the child is abused or neglected and that custody is necessary.

☐ 3. **Functional Impairment:**

The child/adolescent must have a Functional Impairment in two of the listed capacities:

☐ *Functioning in self-care:*

Impairment in self-care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.

☐ *Functioning in community:*

Inability to maintain safety without assistance; a consistent lack of age-appropriate behavioral controls, decision-making, judgment and value systems which result in potential out-of-home placement.

☐ *Functioning in social relationships:*

Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults. Children and adolescents exhibit constrictions in their capacities for shared attention, engagement, initiation of two-way effective communication, and shared social problem solving.

☐ *Functioning in the family:*

Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents and/or caretakers (e.g., foster parents), disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable expectations that may result in removal from the family or its equivalent). Child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well-being. For early childhood functioning, major impairments undermine the fundamental foundation of healthy functioning exhibited by:

- rarely or minimally seeking comfort in distress
- limited positive affect and excessive levels of irritability, sadness or fear
- disruptions in feeding and sleeping patterns
- failure, even in unfamiliar settings, to check back with adult caregivers after venturing away
- willingness to go off with an unfamiliar adult with minimal or no hesitation
- regression of previously learned skills

☐ *Functioning at school/work:*

Impairment in school/work function is manifested by an inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others); identification by an IEP team as having an Emotional/Behavioral Disability; or inability to be consistently employed at a self-sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job).

☐ 4. **Symptoms:**

Symptoms in one of the following groups:

☐ *Psychotic symptoms:*

Symptoms are characterized by defective or lost contact with reality, often with hallucinations or delusions.

☐ *Danger to self, others and property as a result of emotional disturbance:*

The individual is self-destructive, e.g., at risk for suicide, and/or at risk for causing injury to self, other persons, or significant damage to property.

☐ *Mood and anxiety symptoms*

The disturbance is excessive and causes clinically significant distress and which substantially interferes with or limits the child's role or functioning in family, school, or community activities

☐ *Trauma symptoms:*

Children experiencing or witnessing serious unexpected events that threaten them or others. Children and adolescents who have been exposed to a known single event or series of discrete events experience a disruption in their age-expected range of emotional and social developmental capacities. Such children may experience:

- a disruption in a number of basic capacities such a sleep, eating, elimination, attention, impulse control, and mood patterns
- under-responsivity to sensations and become sensory seeking, physically very active, aggressive and/or antisocial
- under-responsivity to sensations but not sensory seeking and may shut down further and become lethargic or depressed and difficult to arouse
- over-responsivity to sensations and become hyper-vigilant or demonstrate fear and panic from being overwhelmed
- episodes of recurrent flashbacks or dissociation that present as staring or freezing

☐ 5. **Duration:**

☐ The disability must be expected to persist for six months or longer.

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Acronyms

ACA	Patient Protection and Affordable Care Act
BHA	Behavioral Health Agency
BHSD	Behavioral Health Services Division
CCSS	Comprehensive Community Support Services
CLNM	CareLink NM
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CNA	Comprehensive Needs Assessment
CRA	Comprehensive Risk Assessment
CSA	Core Service Agency
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
HIPAA	Health Information Portability and Accountability Act
HIT	Health Information Technology
HITECH Act	Health Information Technology for Economic and Clinical Health Act
HSD	New Mexico Human Services Department
ICF/MR/DD	An individual with mental retardation or developmental disabilities with an intermediate care facilities level of care.
IHS	Indian Health Services
IPRA	New Mexico Inspection of Public Records Act
MAD	Medical Assistance Division
MCO	Managed Care Organization
MIS	Management Information System
MMIS	Medicaid Management Information System
NMAC	New Mexico Administrative Code
NMSA	New Mexico Statutes Annotated
PHI	Protected Health Information
PMPM	Per-Member Per-Month
PPA	Provider Participation Agreement
SED	Severe Emotional Disturbance
SMI	Serious Mental Illness
SPA	State Plan Amendment
UR	Utilization Review

ADULT Member Information

These questions are about the person coming in for services today.

I. Background Information	
Today's date	
What brought you in for services today?	
Do you need assistance reading this document? ☐ Yes ☐ No	**Would you like an interpreter?** ☐ Yes ☐ No
Do you have a developmental/intellectual disability? ☐ Yes ☐ No	
If yes, do you have an Individual Service Plan related to your developmental/intellectual disability? ☐ Yes ☐ No	
Do you have an emergency crisis plan (if yes, please give us a copy of the plan)? ☐ Yes ☐ No	
Have you fallen two or more times in the past year? ☐ Yes ☐ No	

II. Demographics/Psychosocial			
Name of person filling out this form (if not patient)			
Relationship to person coming in for services today ☐ Guardian ☐ Other (describe)			
Patient's Name			
Last	**First**	**Middle Initial**	
Date of birth	**Age**		
Address			
Street	**City**	**State**	**Zip**
Phone where patient/guardian may be reached			
Home	**Cell**	**Other**	

In order to provide you with the most appropriate and culturally/linguistically competent care, please respond to the following:

Which of the following best describes you?

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Which of the following best describes you? (check all that apply)

☐ Male ☐ Female ☐ Transgender ☐ Other ☐ Prefer not to identify

Which of the following best describes you?

☐ Heterosexual (straight) ☐ Gay or Lesbian ☐ Bisexual ☐ Not sure

Are you Hispanic or Latino/a?

☐ Yes ☐ No

What is your race? (check all that apply)

☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

☐ Black or African American ☐ Asian ☐ White or Caucasian

What languages do you speak? (check all that apply)

☐ English ☐ Spanish ☐ Pueblo ☐ Other: _____

In what language do you prefer to communicate?

Are there cultural or religious preferences that you would like your provider to be aware of today?

☐ Yes ☐ No

If yes, please describe:

III. General Health Information

Are you currently in any physical pain?

☐ Yes ☐ No

If yes, where is your pain?

How much pain are you in today? Please select the best response, with 0 being no pain and 10 being the most pain you have ever had.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have any serious illness or medical condition?

☐ Yes ☐ No

If yes, please describe:

Have you ever had any serious injuries or accidents?

☐ Yes ☐ No

If yes, please describe:

Have you ever had a traumatic brain injury (head injury, concussion)?

☐ Yes ☐ No

Date of your last:

Physical exam

Date: _____ ☐ Don't know

Dental exam

Date: _____ ☐ Don't know

Vision exam

Date: _____ ☐ Don't know

Hearing exam

Date: _____ ☐ Don't know

Bone density exam

Date: _____ ☐ Don't know

Names of current health/mental health care providers, including specialists:

Do you need help with transportation to appointments?

☐ Yes ☐ No

Do you have enough food to eat in your home?

☐ Yes ☐ No

Do you ever feel worried about having enough to eat?

☐ Yes ☐ No

Is there someone at home, work or anywhere else who makes you feel afraid or threatens you?

☐ Yes ☐ No

Do you feel safe in your current living arrangement?

☐ Yes ☐ No ☐ Prefer not to answer

How do you feel about your life in general?

☐ Terrible ☐ Unhappy ☐ Mostly dissatisfied ☐ Mixed ☐ Mostly Satisfied ☐ Pleased
☐ Delighted ☐ Prefer not to answer

In general, would you say your physical health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Prefer not to answer

In general, would you say your mental health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Prefer not to answer

Overall, how would you rate your functioning in home, social, school and work settings at the present time? Would you say your functioning in these areas is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Prefer not to answer

During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors or groups?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ A lot ☐ Extremely

Have you ever been physically, sexually, or emotionally abused?

☐ Yes ☐ No

In the past 12 months has your spouse, boyfriend/girlfriend ever hit, slapped or hurt you on purpose?

☐ Yes ☐ No

How often do you visit with family who does not live with you?

☐ At least once a day ☐ At least once a week ☐ Less than once a month ☐ Not at all
☐ Don't know ☐ Prefer not to answer ☐ No family

How often do you spend time with someone you consider more than a friend; like a spouse, boyfriend or girlfriend:

☐ At least once a day ☐ At least once a week ☐ Less than once a month ☐ Not at all
☐ Don't know ☐ Prefer not to answer ☐ No spouse, boyfriend or girlfriend

Have you had any psychiatric hospitalization in the last 6 months?

☐ Yes ☐ No ☐ Prefer not to answer

Are you currently taking atypical psychotropic medications, such as Abilify, Clozaril, Zyprexa, Seroquel, Risperdal, or Geodon?

☐ Yes ☐ No ☐ Prefer not to answer

How much are you bothered by medication side effects (for example, shaking and trembling, not being able to think clearly, gaining or losing weight, or sexual problems)?

☐ Not bothered at all ☐ Bothered a little ☐ Bothered moderately ☐ Bothered a lot
☐ Prefer not to answer

IV. Patient Stress Questionnaire

Over the **last two weeks**, how often have you been bothered by any of the following problems?
(please circle your answer and **check the boxes that apply to you)**

	Not at all	Several days	More than half of the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. ☐ Trouble falling or staying asleep, or ☐ Sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. ☐ Poor appetite or ☐ Overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. ☐ Moving or speaking so slowly that other people could have noticed, or ☐ The opposite - being so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3
9. ☐ Thoughts that you would be better off dead, or ☐ Hurting yourself in some way	0	1	2	3
	Add Columns:			

1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3
Adapted from PhQ9, GAD7, PC-PTSD and AUDIT 1/24/11	**Add Columns:**			
			Total:	

Provider: _____

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking.
These questions are about your drinking habits. We've listed the serving size of one drink below.

Please circle your answer	**0**	**1**	**2**	**3**	**4**
How often do you have one drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

How often during the last year have you...	**0**	**1**	**2**	**3**	**4**
…found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…needed a first drink in the morning to get yourself going after heavy drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

	0	**2**	**4**
Have you or someone else been injured as a result of your drinking?	No	Yes, but not in the last year	Yes, during the last year
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year	Yes, during the last year
	Add columns:		
		Total:	

Standard serving of one drink:
12 ounces of beer or wine cooler
1.5 ounces of 80 proof liquor 5 ounces of wine
4 ounces of brandy, liqueur or aperitif

In your life, have you ever had any experience that was so frightening, horrible or upsetting that **in the past month**, you:

1. Have had nightmares about it or thought about it when you did not want to?
☐ Yes ☐ No

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
☐ Yes ☐ No

3. Were constantly on guard, watchful, or easily startled?
☐ Yes ☐ No

4. Felt numb or detached from others, activities, or your surroundings?
☐ Yes ☐ No

V. Columbia Suicide Severity Rating Scale Screener/Recent – Self-Report		
	In the past month	
Answer questions 1 and 2	**Yes**	**No**
1. Have you wished you were dead or wished you could go to sleep and not wake up?		
2. Have you actually had any thoughts about killing yourself?		
If you answered **YES** to 2, answer questions 3, 4, 5 and 6. If you answered **NO** to 2, go directly to question 6.		
3. Have you thought about how you might do this?		
4. Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?		
5. Have you started to work out or worked out the details of how to kill yourself? **Do you intend to carry out this plan?**		
	In the past 3 months	
6. Have you done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, given away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **In your entire lifetime, how many times have you done any of these things?**		

VI. PQ-21 Revised for NMCD

Please indicate whether you have had the following thoughts, feelings and experiences **in the past month** by checking "yes" or "no" for each item. If you answer "YES" to an item, also indicate how distressing that experience has been for you. There are 21 items in total. Please be sure to answer all of them and ask for clarification if you don't understand any words or items.

When answering each item, **do not include experiences that occur only while under the influence of alcohol, drugs or medications that were not prescribed to you**. That is, if you experienced any of the items listed below, but only while you were high on alcohol, drugs or medications that were NOT prescribed to you, then the answer would be NO.

Remember, we are only interested in experiences **in the past month**.

1. Do familiar surroundings sometimes seem strange, confusing, threatening or unreal to you?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

2. Have you heard things that other people don't hear?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

3. Do things that you see appear different from the way they usually do (brighter or duller, larger or smaller, or changed in some other way)?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

4. Have you had experiences with telepathy, psychic forces, or fortune telling?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me:

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

5. Do you sometimes feel as though another person or force is interfering with your thoughts?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

6. Do you have difficulty getting your point across, because you ramble or go off the track a lot when you talk?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

7. Do you have strong feelings or beliefs about being unusually gifted or talented in some way?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

8. When you are walking down the street or on a bus and you hear people talking, do you think they're talking about you?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

9. Do you sometimes get strange feelings on or just beneath your skin, like bugs crawling?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

10. Do you sometimes feel suddenly distracted by distant sounds that you are not normally aware of?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

You are almost done, only 11 items to go. Remember, when answering each item; **do not include experiences that occur only while under the influence of alcohol, drugs or medications that were not prescribed to you**. Also remember we are only interested in experiences in the **past month**.

11. Have you had the sense that some person or force is around you, although you couldn't see anyone?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

12. Do you worry at times that you may be losing your mind, that something may be wrong with it?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

13. Have you ever felt that you don't exist, the world does not exist, or that you are dead?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

14. Have you been confused at times whether something you experienced was real or imaginary?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

15. Do you hold beliefs that other people would find unusual or bizarre?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

16. Do you feel that parts of your body have changed in a way that you can't explain?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

17. Do you ever hear your thoughts out loud?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

18. Do you find yourself feeling mistrustful or suspicious of other people; more than usual?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

19. Have you seen unusual things like flashes, flames, blinding light, or geometric figures?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

20. Have you seen things that other people can't see or don't seem to see?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

21. Do people sometimes find it hard to understand what you are saying?

☐ Yes ☐ No

If yes: When this happens, I feel frightened, concerned, or it causes problems for me.

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

Thank you for completing this form.

Clinical Summary

These questions are about the person coming in for services today.

Today's Date: _____

I. Allergies
Medication(s)?
☐ Yes ☐ No
If yes, what are they?
Food(s)?
☐ Yes ☐ No
If yes, what are they?
Environmental (hay fever, dust etc.)?
☐ Yes ☐ No
If yes, what are they?
Pharmacy name
Pharmacy location
Pharmacy telephone number

Current medications and dose (if known)	How often do you take them?	What are they for?
1.		
2.		
3.		
4.		
5.		

Do you take over the counter medications, herbs, vitamins or supplements?		
☐ Yes ☐ No		
If yes:		
Current vitamins and dose (if known)	**How often do you take them?**	**What are they for?**
1.		
2.		
3.		
4.		
5.		

Do you have trouble taking medications as prescribed?
☐ Yes ☐ No
If yes, would you like help with this?
☐ Yes ☐ No

Other treatments that you are receiving (counseling, psychotherapy, OT, PT, chiropractic, acupuncture, traditional healing, other)
1.
2.
3.
4.
5.

II. Immunizations

Up to date?

☐ Yes ☐ No ☐ Not sure

During the past 12 months have you had either a flu shot or a flu vaccine that was sprayed into your nose?

☐ Yes ☐ No ☐ Don't know/not sure ☐ Refused

A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime, and is different from the flu shot. Have you ever had a pneumonia shot?

☐ Yes ☐ No ☐ Don't know/not sure ☐ Refused

[If respondent is 50 years or older]
Have you ever had the shingles or zoster vaccine?

☐ Yes ☐ No ☐ Don't know/not sure ☐ Refused

Immunization	Yes	No	Check here if within last 10 years
1. Chicken Pox			
2. Flu			
3. Hepatitis A			
4. Hepatitis B			
5. MMR (Measles, Mumps, Rubella)			
6. Meningococcal			
7. Pneumococcal			
8. Shingles			
9. Td/Tdap (Tetanus, Diphtheria)			

III. Medical/Behavioral Health History

These questions are about the person coming in for services today.

Condition/Behavior			**If present, how much are you bothered by this condition/behavior?**			**Would you like to talk about this with your provider?**	
Do you have or have you ever had:	Past	Present	Yes	A little	No	Yes	No
ADHD							
AIDS/HIV							
Alcohol abuse							
Anxiety							
Any heart problems or heart murmur							
Any other significant problems							
Any primary current skin problem (acne, eczema)							
Appendicitis							
Anemia or bleeding problem							
Arthritis							
Asthma, bronchitis, bronchiolitis, pneumonia							
Autism							
Bedwetting							

Condition/Behavior			If present, how much are you bothered by this condition/behavior?			Would you like to talk about this with your provider?	
Do you have or have you ever had:	Past	Present	Yes	A little	No	Yes	No
Bipolar disorder							
Bladder or kidney infection							
Blood transfusion							
Cancer							
Carpal tunnel							
Cataracts							
Chickenpox							
Constipation requiring doctor visits							
Convulsions or neurological problems							
Depression							
Developmental/ Intellectual Disability							
Diabetes							
Dizziness							
Drug abuse							
Eating disorder							
Fainting							
Frequent abdominal pain							
Frequent ear infections							
Frequent headaches							
Gallbladder disease							
Glaucoma							
Gout							
Hallucinations							
Headache							
Hearing problems							
Hepatitis (A, B, C)							
Hernia							
Herpes							
High blood pressure (hypertension)							
Kidney disease							
Legal blindness							
Liver disease							
Low blood pressure (hypotension)							
Lung disease							
Measles							
Mumps							
Mental illness							
Mental retardation							
Nasal allergies							
Neurological disorder							
Overweight or obesity							
Pacemaker							
Physical abuse							
Pneumonia							
Polio							

Condition/Behavior			If present, how much are you bothered by this condition/behavior?			Would you like to talk about this with your provider?	
Do you have or have you ever had:	Past	Present	Yes	A little	No	Yes	No
Problems with ears or hearing							
Problems with eyes or vision							
Rheumatic fever							
Sexual abuse							
Sexually transmitted disease							
Shingles							
Sleep problems							
Stomach problems							
Stroke							
Suicide attempt							
Thyroid or other endocrine problems							
Tobacco use							
Tuberculosis							
Ulcers							
Urinary problems/incontinence/wetting self							
Use of alcohol or drugs							
Violent or aggressive behaviors							
Wandering or running away							

Condition/Behavior		
Do you have or have you ever had:	Yes	No
Problems with teeth?		
Problems with gums?		
Difficulty chewing?		
Difficulty swallowing?		
Appetite change last six months?		
Weight loss?		
Weight gain?		

Men: answer any that apply:

Do you have or have you ever had:	Yes	No	
Penis discharge			
Sore on penis			
Erectile dysfunction			
Testicular lump			
Vasectomy			
PSA			Date:
Prostate problems			
Prostate exam			Date:

Women: answer any that apply:

Period started at age:			
Number of pregnancies:			
Number of live births:			
Number of miscarriages:			
Do you have or have you ever had:	Yes	No	
Birth control			If yes, which one:
Hysterectomy			
Hot flashes			
Hormone replacement			
Vaginal discharge			
Last PAP			Date:
Abnormal PAP			
Intercourse pain			
Sexual problems			
Menstrual irregularity			
Menopause			
Last mammogram			Date:
Breast lump			
Breast self-exam			
Nipple discharge			

IV. Specific Health Concerns	
I would like to talk with or get help from my healthcare provider (check all that apply)	
	Accident or injury prevention
	Ear, eye or mouth care
	Exercise and nutrition
	Health screening tests
	Money, housing case management
	Living will, end-of-life issues
	Long term care needs
	Family or personal problems
	Depression or other mental concerns
	Preventing cancer
	Preventing heart disease
	Problems with my healthcare
	Other

V. Family History										
Have any family members had any of the following? (If so, please check) GM = Grandmother GF = Grandfather										
	Yes	No	Mother	Father	Sister	Brother	GM	GF	Aunt	Uncle
Alcohol abuse										
Anxiety										
Anemia										
Asthma										
ADHD										
Bed wetting after 10 years old										
Bleeding disorder										
Bipolar disorder										
Deafness										
Depression before 50 years old										
Diabetes before 50 years old										
Drug abuse										
Epilepsy or convulsions										
Heart disease before 50 years old										
High cholesterol										
Immune problems, HIV or AIDS										
Kidney disease										
Liver disease										
Mental illness										
Mental retardation										
Nasal allergies										
Overweight or obesity										
Psychosis										
Sleep problems										
Tuberculosis										
Additional family history:										

VI. Emergency Department Visits			
Date:	Reason:	Date:	Reason:
Date:	Reason:	Date:	Reason:
VII. Medical/Psychiatric Hospitalizations			
Date:	Reason:	Date:	Reason:
Date:	Reason:	Date:	Reason:
VIII. Surgeries			
Date:	Reason:	Date:	Reason:
Date:	Reason:	Date:	Reason:
IX. Substance Abuse Treatment			
Date:	Reason:	Date:	Reason:
Date:	Reason:	Date:	Reason:

Health and Well-Being

I. Legal
Do you have an advance directive and/or a living will?
☐ Yes ☐ No
Do you have a copy of your advance directive and/or living will to put in your record?
☐ Yes ☐ No
Do you have a psychiatric advance directive?
☐ Yes ☐ No
Do you have a copy of the psychiatric advance directive to put in your record?
☐ Yes ☐ No
Have you given Power of Attorney to someone?
☐ Yes ☐ No
If yes, who?
Do you have a copy of the Power of Attorney to put in your record?
☐ Yes ☐ No
In the past six months, have you been arrested?
☐ Yes ☐ No ☐ Don't know ☐ Prefer not to answer ☐ N/A
In the past six months, have you spent at least one night in jail?
☐ Yes ☐ No ☐ Don't know ☐ Prefer not to answer ☐ N/A
In the past six months, were you a victim of any violent crimes, such as assault, rape, mugging or robbery?
☐ Yes ☐ No ☐ Don't know ☐ Prefer not to answer ☐ N/A

II. Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

Please indicate your ability to do the activities in the table below. If you are receiving help for any of these, mark that as well.

Function	Independent	Need Help	Dependent	Cannot Do	Receiving Help
Bathing					
Dressing					
Grooming					
Mouth care					
Toileting					
Transferring bed/chair					
Walking					
Climbing stairs					
Eating					
Shopping					
Cooking					
Managing medications					
Using phone book/ looking up numbers					
Doing housework					
Doing laundry					
Driving or using public transportation					
Managing finances					

Do you have a caregiver that comes into the home, because of a health care problem, to provide you with assistance?

☐ Yes ☐ No

If caregiver is from an agency, please enter their name here:

If caregiver is a relative or friend, please enter their name here:

Caregiver's (or agency's) phone number:

How many hours per day/week does your caregiver come into your home?

What does your caregiver do?

Do you need more help than you are receiving?

☐ Yes ☐ No

Please explain:

III. Health

During a usual week, what do you do most of the time?

☐ Work at a job for pay ☐ Go to structured day program ☐ Go to school
☐ Do volunteer work ☐ Keep house ☐ Care for child/children or other relative
☐ Nothing much (e.g., drink coffee, smoke cigarettes, watch T.V. etc.)
☐ Other (please specify):_____

Do you participate in activities such as walking, hiking, aerobics, water aerobics or bicycling for at least 30 min a day/3 days a week?

☐ Yes ☐ No

How many hours a day do you watch TV, play video games, or spend time on a computer, tablet, or smartphone (not including for work)? (Please check number of hours)

☐ Less than 1 hour ☐ 1-2 hours ☐ 3-4 hours ☐ 4-5 hours ☐ 4-8 hours
☐ More than 8 hours

Do you usually eat 5 or more servings of vegetables and fruits every day?

☐ Yes ☐ No

How many times a week do you eat at a fast food restaurant?

# of times: _____

On average, how many hours of sleep do you get in a 24 hour period?

# of hours: _____

Do you feel your sleep is restful?

☐ Yes ☐ No

During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ A lot ☐ Extremely

During the past four weeks, was someone available to give you the help you needed and wanted?

☐ Yes, as much as I wanted ☐ Yes, quite a bit ☐ Yes, some ☐ Yes, a little
☐ No, not at all

During the past four weeks, what was the hardest physical activity you could do for at least two minutes?

☐ Very heavy ☐ Heavy ☐ Moderate ☐ Light ☐ Very light

IV. Client Concerns
Do you have any concerns or questions about your body or your physical appearance?
☐ Yes ☐ No
If yes, please describe:
On the whole, how much do you like yourself?
☐ Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ A lot
What are your future plans for work, career and family goals?

V. Safety/Injuries
How often do you use seatbelts when you drive/ride in a car, truck, van or similar?
☐ Always ☐ Nearly always ☐ Sometimes ☐ Seldom ☐ Never
Do you wear a helmet when roller blading, biking, motorcycling, riding an ATV, skiing, or snowboarding?
☐ Yes ☐ No
Do you text, talk or surf the Internet on your cell phone while you are driving?
☐ Yes ☐ No
Do you protect yourself from sun when you're outdoors; such as wearing a hat, long sleeved shirt and using sunscreen?
☐ Yes ☐ No
Have you ever carried a weapon (gun, knife, etc.) to protect yourself?
☐ Yes ☐ No
Have you ever been in foster care, group homes, or been homeless?
☐ Yes ☐ No
Have you ever been in jail or in a detention center?
☐ Yes ☐ No
Do you have a gun/firearm in the home?
☐ Yes ☐ No
If yes, is it unloaded?
☐ Yes ☐ No
If yes, is it locked up?
☐ Yes ☐ No
During the past 12 months did you:
Smoke any marijuana or hashish?
☐ Yes ☐ No
Use anything else to get high (includes illegal drugs, over-the-counter and prescription drugs, and things you sniff or huff)?
☐ Yes ☐ No
If you answered yes to the above question, please complete questions a. through e.
a. Do you ever use drugs to relax, feel better about yourself or fit in?
☐ Yes ☐ No
b. Do you ever use drugs while you're by yourself, alone?
☐ Yes ☐ No
c. Have you ever gotten into trouble while you were using drugs?
☐ Yes ☐ No
d. Do you ever forget things you did while using drugs?
☐ Yes ☐ No
e. Does your family or friends ever tell you that you should cut down on your drug use?
☐ Yes ☐ No

VI. Relationship/Sexual Activity

Have you ever had sex (including vaginal, oral, or anal sex)?

☐ Yes ☐ No

If you answered "yes" to the question above, please complete questions a. through g.

a. Do you always use condoms when you have sex?

☐ Yes ☐ No

b. Does your partner(s) always use condoms when they have sex?

☐ Yes ☐ No

c. Are you using a method to prevent pregnancy?

☐ Yes ☐ No

If so, which types (condoms, pills, Depo shot, patch, Nexplanon/Implanon, foam, sponge, withdrawal, ring, IUD)?

d. Have you ever been pregnant or gotten someone pregnant?

☐ Yes ☐ No

e. During your life, have you had sexual contact with (check):

☐ Females ☐ Males ☐ Females and Males ☐ Other _____

f. Do you think you could have a sexually transmitted infection?

☐ Yes ☐ No

g. Do you think your partner could have a sexually transmitted infection?

☐ Yes ☐ No

VII. Health Behaviors/Substance Abuse

In the past three months have you smoked cigarettes or used any form of tobacco (e.g. chew, dip, cigars, hookah and/or e-cigarettes)?

☐ Yes ☐ No

Have you ever ridden in a car driven by someone (including yourself) that was high or was using alcohol or drugs?

☐ Yes ☐ No

Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

☐ Yes ☐ No

Keeping track of your medications?

☐ Yes ☐ No

How often do you have trouble taking medicines the way you have been told to take them?

☐ Do not have to take medicine ☐ Always take as prescribed

☐ Sometimes take as prescribed ☐ Seldom take as prescribed

Does anyone in your home take opioids for an ongoing medical condition? (OxyContin, Hydrocodone, Codeine)

☐ Yes ☐ No

Do you lock your opioid medications in a medicine cabinet or other locked location?

☐ Yes ☐ No

How confident are you that you can control and manage most of your health problems?

☐ Very confident ☐ Somewhat confident

Are you afraid of falling?

☐ Yes ☐ No

Do you have a smoke detector in your home?

☐ Yes ☐ No

Do you have gas heating or appliances in your home?

☐ Yes ☐ No

If yes, do you have a carbon monoxide detector?

☐ Yes ☐ No

Do you have area rugs in your home?

☐ Yes ☐ No

When walking in your home, are the areas free from clutter?

☐ Yes ☐ No

Is your home free from pests (e.g., roaches, ants and spiders)?

☐ Yes ☐ No

In the past six months, how often did you talk to a member of your family on the telephone or through email?

☐ At least once a day ☐ At least once a week ☐ At least once a month
☐ Less than once a month ☐ Not at all ☐ Don't know ☐ Prefer not to answer
☐ No family

In the past six months, how often did you get together with a member of your family?

☐ At least once a day ☐ At least once a week ☐ At least once a month
☐ Less than once a month ☐ Not at all ☐ Don't know ☐ Prefer not to answer
☐ No family

Did you ever serve in the armed forces or the National Guard?

☐ Yes ☐ No

If yes, please check all that apply:

Airforce Army Coast Guard Navy Marines

Are you active military now?

☐ Yes ☐ No

If no, please check the type of discharge you received.

☐ Honorable ☐ General ☐ Undesirable ☐ Bad conduct
☐ Dishonorable or Dismissal ☐ Other _____

VIII. Durable Medical Equipment (please check)			
	Have	**Want**	**Wish to discuss**
Air-fluidized beds and other support surfaces			
Bar in toilet/shower			
Blood sugar (glucose) test strips			
Blood sugar monitors			
Canes (however, white canes for the blind aren't covered)			
Commode chairs			
Continuous passive motion (CPM) machine			
Crutches			
Eyeglasses/contacts			
Hearing aid or other hearing equipment			
Hospital beds			
Infusion pumps and supplies (when necessary to administer certain drugs)			
Manual wheelchairs and power mobility devices			
Nebulizers and nebulizer medications			
Oxygen equipment and accessories			
Patient lifts			
Shower bench			
Sleep apnea and Continuous Positive Airway Pressure (CPAP) devices and accessories			
Suction pumps			
Traction equipment			
Translation devices			

	Have	Want	Wish to discuss
Walkers			
Wheelchair			

Do you have other adaptive equipment that is not listed above?

☐ Yes ☐ No

If yes, please describe:

Do you want other adaptive equipment that is not listed above?

☐ Yes ☐ No

If yes, please describe:

IX. Employment

What is your current type of employment?

- ☐ Employed – no support
- ☐ Supported employment
- ☐ Supported employment/micro-enterprises
- ☐ Consumer operated business
- ☐ Transitional employment
- ☐ Sheltered workshop
- ☐ Not employed, but seeking employment
- ☐ Not employed, not seeking employment
- ☐ Not in the labor force (e.g., retired, disabled, homemaker, student, volunteer)
- ☐ Prefer not to answer

If not employed (check all that apply):

- ☐ I don't want to risk losing my benefits
- ☐ I worry that my symptoms will interfere with my work
- ☐ I'm not sure how to go about finding a job
- ☐ I lack the skills necessary to do the kind of work I want
- ☐ Other
- ☐ Prefer not to answer

If employed, for how long have you been in the same job?

☐ Less than 6 months ☐ 6 months to 1 year ☐ Greater than 1 year

☐ Prefer not to answer

If employed, how many hours do you work per week?

# of hours: _____

Are you having any of the following problems at work? (check all that apply)

☐ Missing work ☐ Poor work conditions ☐ Late for work ☐ Other

☐ Harassment (in person, or through social media) ☐ I don't have any of these problems

X. Financial Supports
In the past six months, did you generally have enough money each month to cover:
a. Food
☐ Yes ☐ No
b. Clothing
☐ Yes ☐ No
c. Housing
☐ Yes ☐ No
d. Traveling around to get things, shopping, medical appointments, or visiting friends or relatives?
☐ Yes ☐ No
e. Social activities like movies or eating in restaurants?
☐ Yes ☐ No
f. Heating, air conditioning, water, electricity, gas?
☐ Yes ☐ No
Have you received mental health or developmental disability services?
☐ Yes ☐ No
Do you have questions you would like to discuss with your provider?
☐ Yes ☐ No
Do you know what benefits are available to you?
☐ Yes ☐ No
Do you feel that your benefits meet your needs?
☐ Yes ☐ No

Action Plan

I. Personal Health Plan				
How involved would you like to be in the planning and development of your behavioral/health care and treatment plan? Please check the best answer for your preference.				
☐ Not at all involved ☐ A little involved ☐ Somewhat involved ☐ Involved ☐ Very involved				
I plan to improve myself and/or set goals in the following areas in order of their importance (priority):				
Area(s):	**What do I plan to do to improve this?**	**What barriers might get in the way of me improving myself or meeting my goals?**	**How confident am I in achieving my goals?**	**Schedule to follow up with Care Manager**
1.			☐ Not Confident ☐ A Little Confident ☐ Average Confidence ☐ Confident ☐ Very Confident	☐ Yes ☐ No If yes, date: _____
2.			☐ Not Confident ☐ A Little Confident ☐ Average Confidence ☐ Confident ☐ Very Confident	☐ Yes ☐ No If yes, date: _____
3.			☐ Not Confident ☐ A Little Confident ☐ Average Confidence ☐ Confident ☐ Very Confident	☐ Yes ☐ No If yes, date: _____
4.			☐ Not Confident ☐ A Little Confident ☐ Average Confidence ☐ Confident ☐ Very Confident	☐ Yes ☐ No If yes, date: _____
5.			☐ Not Confident ☐ A Little Confident ☐ Average Confidence ☐ Confident ☐ Very Confident	☐ Yes ☐ No If yes, date: _____
6.			☐ Not Confident ☐ A Little Confident ☐ Average Confidence ☐ Confident ☐ Very Confident	☐ Yes ☐ No If yes, date: _____

Special accommodations needed for visit (large room, extra time, etc.):
What needs to be done before we meet next?
Upcoming appointments and procedures:
Who needs to be at the next meeting?
Next Care Coordination appointment date:
What will we meet about?
Where will we meet?
What time will we meet?

II. Care Plan

CHILD Member Information

These questions are about the person coming in for services today.

I. Background Information	
Today's date	
What brought you/your child in for services?	
Do you/Does your child need assistance reading this document? ☐ Yes ☐ No	**Would you/your child like an interpreter?** ☐ Yes ☐ No
Do you/Does your child have a developmental/intellectual disability? ☐ Yes ☐ No	
If yes, do you/they have an Individual Service Plan related to your/their developmental/intellectual disability? ☐ Yes ☐ No	
Do you/Does your child have an emergency crisis plan? (if yes, please give us a copy of the plan) ☐ Yes ☐ No	

II. Demographics/Psychosocial			
Name of person filling out this form (if not patient)			
Relationship to person coming in for services today ☐ Guardian ☐ Other (describe)			
Patient's Name			
Last	**First**	**Middle Initial**	
Date of birth	**Age**		
Address			
Street	**City**	**State**	**Zip**
Phone where patient/guardian may be reached			
Home	**Cell**	**Other**	
Parent Name(s)			
Who has legal custody (parent(s), guardian, agency and staff member name, other)?	**Phone**		

In order to provide you/your child with the most appropriate and culturally/linguistically competent care, please respond to the following:

Which of the following best describes you/your child? (check all that apply)

☐ Male ☐ Female ☐ Transgender ☐ Other ☐ Prefer not to identify

Which of the following best describes you/your child?

☐ Heterosexual (straight) ☐ Gay or Lesbian ☐ Bisexual ☐ Not sure

Are you/Is your child Hispanic or Latino/a?

☐ Yes ☐ No

What is your/your child's race? (check all that apply)

☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander
☐ Black or African American ☐ Asian ☐ White or Caucasian

What languages do you/does your child speak? (check all that apply)

☐ English ☐ Spanish ☐ Pueblo ☐ Other

In what language do you/does your child prefer to communicate?

Are there cultural or religious preferences that you/your child would like your/their provider to be aware of today?

☐ Yes ☐ No

If yes, please describe:

III. Home

How many people live in your/your child's home, including you/your child?

Who lives in your/your child's home with you/your child? (check all that apply)

☐ Mother ☐ Stepmother ☐ Father ☐ Stepfather
☐ Two Mothers ☐ Two Fathers ☐ Mother's boyfriend ☐ Father's girlfriend
☐ Boyfriend/partner ☐ Girlfriend/partner ☐ Spouse/Partner's Mother or Father
☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ Cousin
☐ Foster Parent ☐ Friend ☐ Other relatives ☐ Pet

Are you/Is your child having any problems at home? (check all that apply)

☐ Violence ☐ Money ☐ Fighting ☐ House ☐ Food ☐ Gas
☐ Electricity ☐ Water ☐ Cooling ☐ You are/Your child is out of work
☐ Spouse/Partner out of work ☐ Substance use of others ☐ Concerns with a family member
☐ We don't have any of these problems

If you checked any of the above, where do you/does your child go for help?

Who do you/Does your child feel you/your child can really talk to? (check all that apply)

☐ Friend ☐ Parents ☐ Other adults ☐ Brother/Sister
☐ Teacher ☐ Only friend ☐ Other relatives ☐ Other

IV. School

Are you/your child in school? (please check)

☐ No ☐ No, but interested in attending school ☐ Yes, full time ☐ Yes, part time
☐ Prefer not to answer

Highest grade completed (check one)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ Trade
☐ Other

Did you/your child ever attend special education classes while in school?

☐ Yes ☐ No

If not in school in past 6 months have you/has your child: (please check)

- ☐ Never been in any type of school or received any schooling
- ☐ Dropped out of school before reaching legal age to drop out
- ☐ Dropped out after reaching the legal age
- ☐ Been expelled
- ☐ Been suspended
- ☐ Graduated from high school/got GED
- ☐ Had physical illness and/or injury
- ☐ Refused to go to school
- ☐ Been in juvenile detention or jail (and schooling was not provided)
- ☐ Been asked to leave school (e.g., due to behavior)
- ☐ Had no instruction provided while waiting for another placement
- ☐ Other

How often were you/was your child usually absent from school in the past 6 months (this includes excused as well as unexcused absences)?

☐ Less than 1 day a month ☐ About 1 day a month ☐ About 1 day every 2 weeks
☐ About 1 or 2 days per week ☐ 3 or more days per week

In the past 6 months, to what extent do you/does your child think school attendance was affected by behavioral or emotional problems?

☐ Not at all ☐ A little bit ☐ A moderate amount ☐ Quite a bit ☐ Extremely

In the past 6 months, to what extent did your/your child's school provide support to help improve your/their attendance?

☐ Not at all ☐ A little bit ☐ A moderate amount ☐ Quite a bit ☐ Extremely

V. Financial Supports

These questions are about the person coming in for services today.

What is your/your child's annual income before taxes from all sources except food stamps? (check one)

☐ Under $10,000 ☐ $10,001-20,000 ☐ $20,001-30,000 ☐ $30,001-40,000
☐ $40,001-50,000 ☐ $50,001 or more ☐ Don't know

Do you/Does your child currently receive any of the following or are you/is your child on: (check all that apply)

☐ SSI ☐ Medicaid ☐ SSDI ☐ Medicare ☐ Disability ☐ Self pay
☐ Insurance ☐ General assistance ☐ Medically fragile (Alternative Benefit Plan)
☐ Prefer not to answer

What is your/your child's current living arrangement?

- ☐ Independent (living on your/their own or with family/others or semi-independent)
- ☐ HUD Rental Subsidy (Section 8)
- ☐ HUD Shelter + Care Rental Subsidy Program
- ☐ Supported Housing/Bridge Subsidy Program
- ☐ 8-16 hour group home
- ☐ 24-hour group home
- ☐ Licensed Specialized Residential Services
- ☐ Care home
- ☐ Nursing home
- ☐ Hospital
- ☐ Licensed Crisis Residential Services
- ☐ Hospice
- ☐ Homeless shelter
- ☐ Homeless Unsheltered
- ☐ Incarcerated

If you selected independent, supported housing, or HUD, do you/does your child live alone?

☐ Not alone ☐ Alone ☐ Alone with a pet ☐ Prefer not to answer

Have you/your child been homeless at any time in the last 6 months?

☐ Yes ☐ No ☐ Prefer not to answer

In the past six months, did you/your child generally have enough money each month to cover:

a. food?

☐ Yes ☐ No

b. clothing?

☐ Yes ☐ No

c. housing?

☐ Yes ☐ No

d. traveling around to get things, shopping, medical appointments, or visiting friends or relatives?

☐ Yes ☐ No

e. social activities like movies or eating in restaurants?

☐ Yes ☐ No

f. heating, air conditioning, water, electricity, gas?

☐ Yes ☐ No

Would you/your child like to discuss this with someone?

☐ Yes ☐ No

Have you/Has your child received mental health or developmental disability services?

☐ Yes ☐ No

Do you/Does your child have questions or do you/they have questions you/they would like to discuss with your/their provider?

☐ Yes ☐ No

VI. General Health Information

Are you/Is your child currently in any physical pain?

☐ Yes ☐ No

If yes, where is your/your child's pain?

How much pain are you/is your child in today? Please select the best response, with 0 being no pain and 10 being the most pain you/your child have/has ever had.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you consider yourself/your child to be in good health?

☐ Yes ☐ No

If no, please explain:

Do you/Does your child have any serious illness or medical condition?

☐ Yes ☐ No

If yes, please describe:

Have you/Has your child ever had any serious injuries or accidents?

☐ Yes ☐ No

If yes, please describe:

Have you/Has your child ever had a surgery?

☐ Yes ☐ No

If yes, please describe:

Have you/Has your child been hospitalized?

☐ Yes ☐ No

If no, please explain:

Date of your/your child's last:

Physical exam

Date: ☐ Don't know

Dental exam

Date: ☐ Don't know

Vision exam

Date: ☐ Don't know

Hearing exam

Date: ☐ Don't know

Have you/Has your child ever had a traumatic brain injury (i.e. head injury, concussion)?

☐ Yes ☐ No

If yes, please describe:

Names of current health/mental health care providers, including specialists:

Do you/Does your child need help with transportation to appointments?

☐ Yes ☐ No

Do you/Does your child have enough food to eat in your home?

☐ Yes ☐ No

Do you/Does your child ever feel worried about having enough to eat?

☐ Yes ☐ No

Do you/ Does your child have electricity/gas and/or water in your home?

☐ Yes ☐ No

VII. Occupation

In the past six months have you/has your child had a job, including formal jobs (e.g. working in a restaurant or store) or done other paid work (e.g., babysitting, mowing lawns)?

☐ Yes ☐ No

In how many of the past 6 months have you/has your child worked?

Number of months:_____

How much money do you/does your child make per week?

$

How many days in the past 6 months did you/your child miss work due to emotional and behavioral problems, if any?

Number of days:

Which of the following best describes why you/your child have/has not worked in the past 6 months (check only the best answer)?

- ☐ Was trying to find a job but could not find one
- ☐ Do not have time to work
- ☐ Caregivers do not want me/my child to work
- ☐ Attending school
- ☐ Not able to work for physical or emotional reasons
- ☐ Other (specify):

Clinical Summary

These questions are about the person coming in for services today.

Today's Date: _____

I. Allergies
Medication(s)?
☐ Yes ☐ No
If yes, what are they?
Food(s)?
☐ Yes ☐ No
If yes, what are they?
Environmental (hay fever, dust etc.)?
☐ Yes ☐ No
If yes, what are they?
Pharmacy name
Pharmacy location
Pharmacy telephone number

Current medications and dose (if known)	How often do you/does your child take them?	What are they for?
1.		
2.		
3.		
4.		
5.		

Now or in the past 6 months, have you/has your child taken any prescribed medications for emotional or behavioral symptoms?
☐ Yes ☐ No
If yes, have the medications helped you/your child feel better?
☐ Yes ☐ No
If yes, in what ways have they helped you/your child feel better?
In the past 6 months have you/has your child had any bad side effects from these medications?
☐ Yes ☐ No
If yes, what were the bad side-effects?

Do you/ Does your child take over the counter medications, herbs, vitamins or supplements?	
☐ Yes ☐ No	
If yes, what are they and what are they for?	
Name and dose (if known)	**What are they for?**
1.	
2.	
3.	
4.	
5.	
Do you/Does your child have trouble taking medications as prescribed?	
☐ Yes ☐ No	
If yes, would you/your child like help with this?	
☐ Yes ☐ No	

Other treatments that you are/your child is receiving (counseling, psychotherapy, occupational therapy, physical therapy, chiropractor, acupuncture, shaman, medicine man, other)
1.
2.
3.
4.
5.

II. Immunizations

Please check any of the following immunizations you have/your child has received.

Immunization	Yes	No	Don't know/ not sure	Refused
DTaP (diptheria, tetanus, acellular pertussis; 5 doses at 2, 4 6, 15 -18 mo & 4-6 yrs; <7 yrs)				
Td/Tdap (Tetanus, diphtheria, pertussis; 11 to 12 yrs; 10 yr boosters)				
PCV13 (Pneumococcal conjugate; 4 doses at 2, 4, 6, 12 or 15 mos)				
MMR (measles, mumps rubella; 2 doses 12-15 mos & 4-6 yrs)				
Meningococcal (2 doses; 11-12 yrs and booster 16-18 yrs)				
Hepatitis A (2 doses; and 18-23 mos)				
Hepatitis B (3 doses, birth, 1 to 2 mo & 6 to 18 mos)				
Hib (Haemophilus influenzae type b; 4 doses at 2, 4, 12 or 15 mos)				
HPV (Human Papilloma Virus; ages 11 to 26 females; ages 11 to 21 males)				
IPV (Inactivated poliovirus; 4 doses ; 2, 4, 6 -18 mos & 4-6 yrs; <18 yrs)				
Influenza (annual dose beginning at 6 mos)				
Rotavirus 3 (2 doses 2, 4 and 6 to 15 mos)				

III. Medical/Behavioral Health History These questions are about the person coming in for services today.							
			If present, are you/is your child bothered by this condition/behavior?			Would you/your child like to talk about this with your/your child's provider?	
Do you/Does your child have or have you/has your child ever had:	Past	Present	Yes	A little	No	Yes	No
ADHD							
AIDS/HIV							
Alcohol abuse							
Anxiety							
Any heart problems or heart murmur							
Any other significant problems							
Any primary skin problem (acne, eczema etc.)							
Appendicitis							
Anemia or bleeding problem							
Arthritis							
Asthma, bronchitis, bronchiolitis, pneumonia							
Autism							
Bedwetting							
Bipolar disorder							
Bladder or kidney infection							
Blood transfusion							
Cancer							
Carpal tunnel							
Cataracts							
Chickenpox							
Constipation requiring doctor visits							
Convulsions or neurological problems							
Depression							
Developmental/intellectual disability							
Diabetes							
Dizziness							
Drug abuse							
Eating disorder							
Fainting							
Frequent abdominal pain							
Frequent ear infections							
Frequent headaches							
Gallbladder disease							
Glaucoma							
Gout							
Hallucinations							
Headache							
Hearing problems							

			If present, are you/your child bothered by this condition/behavior?			Would you/your child like to talk about this with your/your child's provider?	
Do you/Does your child have or have you/has your child ever had:	Past	Present	Yes	A little	No	Yes	No
Hepatitis (A, B, C)							
Hernia							
Herpes							
High blood pressure (hypertension)							
Kidney disease							
Liver disease							
Low blood pressure (hypotension)							
Lung disease							
Measles							
Mumps							
Mental illness							
Mental retardation							
Nasal allergies							
Neurological disorder							
Obesity or been overweight							
Pacemaker							
Physical abuse							
Pneumonia							
Polio							
Problems with eyes or vision							
Legal blindness							
Problems with ears or hearing							
Rheumatic fever							
Sexual abuse							
Sexually transmitted disease							
Shingles							
Sleep problems							
Stomach problems							
Stroke							
Suicide attempt							
Thyroid or other endocrine problems							
Tobacco use							
Tuberculosis							
Ulcers							
Urinary problems/incontinence/wetting self							
Use of alcohol or drugs							
Violent or aggressive behaviors							
Wandering or running away							

Do you/Does your child have or have you/they ever had:

Problems with teeth?

☐ Yes ☐ No

Problems with gums?

☐ Yes ☐ No

Difficulty chewing?

☐ Yes ☐ No

Difficulty swallowing?

☐ Yes ☐ No

Appetite change last six months?

☐ Yes ☐ No

Weight loss?

☐ Yes ☐ No

Weight gain?

☐ Yes ☐ No

IV. Relationship/Sexual Activity

Have you/Has your child ever had sex (including vaginal, oral, or anal sex)?

☐ Yes ☐ No

If you/your child answered "yes" to the question above, please complete questions a. through g.

a. Do you/Does your child always use condoms when you/they have sex?

☐ Yes ☐ No

b. Does your/your child's partner(s) always use condoms when they have sex?

☐ Yes ☐ No

c. Are you/Is your child using a method to prevent pregnancy?

☐ Yes ☐ No

If so, which types (condoms, pills, Depo shot, patch, Nexplanon/Implanon, foam, sponge, withdrawal, ring, IUD etc.)?

d. Have you/Has your child ever been pregnant or gotten someone pregnant?

☐ Yes ☐ No

e. During your/your child's life, have you/they had sexual contact with (check):

☐ Females ☐ Males ☐ Females and Males ☐ Other _____

f. Do you/Does your child think you/they could have a sexually transmitted infection?

☐ Yes ☐ No

g. Do you/Does your child think your/their partner could have a sexually transmitted infection?

☐ Yes ☐ No

Males:

Do you/Has your child have or have you ever had:
Penis discharge?
☐ Yes ☐ No
Sore on penis?
☐ Yes ☐ No
Erectile dysfunction?
☐ Yes ☐ No
Testicular lump?
☐ Yes ☐ No

Females: answer any that apply

Period started at age:
Number of pregnancies:
Number live births:
Number of miscarriages:
Birth control?
☐ Yes ☐ No
If yes, which one:
Vaginal discharge?
☐ Yes ☐ No
Intercourse pain?
☐ Yes ☐ No
Sexual problems?
☐ Yes ☐ No
Menstrual irregularity?
☐ Yes ☐ No

V. Family History										
Have any family members had any of the following? (If so, please check) GM = Grandmother GF = Grandfather										
	Yes	**No**	**Mother**	**Father**	**Sister**	**Brother**	**GM**	**GF**	**Aunt**	**Uncle**
Alcohol abuse										
Anxiety										
Anemia										
Asthma										
ADHD										
Bed wetting after 10 years old										
Bleeding disorder										
Bipolar disorder										
Deafness										
Depression before 50 years old										
Diabetes before 50 years old										
Drug abuse										
Epilepsy or convulsions										
Heart disease before 50 years old										
High blood pressure before 50 years old										
High cholesterol										
Immune problems, HIV or AIDS										
Kidney disease										
Liver disease										
Mental illness										
Mental retardation										
Nasal allergies										
Obesity or been overweight										
Psychosis										
Sleep problems										
Tuberculosis										
Additional family history:										

VI. Emergency Department Visits			
Date:	Reason:	Date:	Reason:
Date:	Reason:	Date:	Reason:
VII. Medical/Psychiatric Hospitalizations			
Date:	Reason:	Date:	Reason:
Date:	Reason:	Date:	Reason:
VIII. Surgeries			
Date:	Reason:	Date:	Reason:
Date:	Reason:	Date:	Reason:
IX. Substance Abuse Treatment			
Date:	Reason:	Date:	Reason:
Date:	Reason:	Date:	Reason:

Development and Well-Being

These questions are about the person coming in for services today.

I. Birth History
Birth weight
_____ pounds ☐ Don't know
Was the delivery vaginal?
☐ Yes ☐ No ☐ Don't know
Was the baby delivered via C-section?
☐ Yes ☐ No ☐ Don't know
Was the baby born at term?
☐ Yes ☐ No ☐ Don't know
Was the baby born early?
☐ Yes ☐ No ☐ Don't know
If the baby was born early, at how many weeks gestation?
_____ weeks ☐ Don't know
Did the baby have any problems right after birth?
☐ Yes ☐ No ☐ Don't know
Was there any illness or problems with the mother's pregnancy?
☐ Yes ☐ No ☐ Don't know
During the pregnancy, did the mother smoke?
☐ Yes ☐ No ☐ Don't know
If yes, what did she smoke?
_____ ☐ Don't know
During the pregnancy, did the mother drink alcohol?
☐ Yes ☐ No ☐ Don't know
If yes, when during the pregnancy did she drink?
_____ ☐ Don't know
During the pregnancy, did the mother use drugs/medicines?
☐ Yes ☐ No ☐ Don't know
Did the baby go home with the mother from the hospital?
☐ Yes ☐ No ☐ Don't know

II. Development
Are you concerned about your/your child's physical development?
☐ Yes ☐ No
Explain:
Are you concerned about your/your child's mental or emotional development?
☐ Yes ☐ No
Explain:

If in school:

Are you/Is your child having problems with behavior at school?

☐ Yes ☐ No

Explain:

Have you/Has your child failed or repeated a grade?

☐ Yes ☐ No

Explain:

Are you/Is your child having academic problems in school?

☐ Yes ☐ No

Explain:

Are you/Is your child in special resource classes?

☐ Yes ☐ No

Explain:

III. Caregiver

Do you/Does your child have a caregiver who comes into the home, because of a health care problem, to provide you/your child with assistance?

☐ Yes ☐ No

If you have/your child has a caregiver that is a relative or friend, please enter their name:

Caregiver's (or agency's) phone number:

How many hours per day/week does your/your child's caregiver come into the home?

What does your/your child's caregiver do?

Do you/Does your child need more help than you/your child are receiving?

☐ Yes ☐ No

Please explain:

IV. Legal

Do you/Does your child have an advance directive and/or a living will?

☐ Yes ☐ No

Do you/Does your child have a copy of your/their advance directive/living will to put in your/their record?

☐ Yes ☐ No

Do you/Does your child have a psychiatric advance directive?

☐ Yes ☐ No

Do you/Does your child have a copy of the psychiatric advance directive to put in your/their record?

☐ Yes ☐ No

Have you/Has your child given Power of Attorney to someone?

☐ Yes ☐ No

If yes, who?

Do you/Does your child have a copy of the Power of Attorney to put in your/your child's record?

☐ Yes ☐ No

V. Client Concerns

These questions are about the person coming in for services today.

Do you/Does your child have any concerns or questions about the size or shape of your/their body or physical appearance?

☐ Yes ☐ No

If yes, please describe:

On the whole, how much do you/does your child you like yourself/themselves?

☐ Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ A lot

What are your/your child's future plans for having a family and career goals?

VI. Health Behaviors

Questions refer to the child patient activities.

Do you/Does your child usually participate in physical activities such as walking, skateboarding, dancing, swimming or playing basketball, baseball, for a total of one hour per day?

☐ Yes ☐ No

Do you/Does your child usually watch TV, play video games, or spend time on a computer, tablet, or smartphone for more than 2 hours per day (not including computer time for school or work)?

☐ Yes ☐ No

Do you/Does your child usually eat 5 or more servings of vegetables and fruits every day?

☐ Yes ☐ No

Do you/Does your child usually get 8 or more hours of sleep every night?

☐ Yes ☐ No

In the last 6 months have you/has your child seen a dentist or gone to a dental clinic?

☐ Yes ☐ No

Do you/Does your child have any tooth pain right now?

☐ Yes ☐ No

How often can you/your child depend on having someone your/your child's own age to talk to?

☐ Never ☐ Rarely/almost never ☐ Less than half the time ☐ More than half the time
☐ Usually Almost always ☐ Always

How often can you/your child depend on having an adult to talk to?

☐ Never ☐ Rarely/almost never ☐ Less than half the time ☐ More than half the time
☐ Usually Almost always ☐ Always

If a problem or emergency arises, how often can you/your child depend on someone your/your child's own age to turn to for help and support?

☐ Never ☐ Rarely/almost never ☐ Less than half the time ☐ More than half the time
☐ Usually ☐ Almost always ☐ Always

If a problem or emergency arises, how often can you/your child depend on having an adult to turn to for help and support?

☐ Never ☐ Rarely/almost never ☐ Less than half the time ☐ More than half the time
☐ Usually ☐ Almost always ☐ Always

How often do you/does your child have someone your/your child's own age to have fun with or hang out with when you/your child want(s) to?

☐ Never ☐ Rarely/almost never ☐ Less than half the time ☐ More than half the time
☐ Usually ☐ Almost always ☐ Always

How often do you/does your child have an adult to have fun with or hang out with when you/your child want(s) to?

☐ Never ☐ Rarely/almost never ☐ Less than half the time ☐ More than half the time
☐ Usually ☐ Almost always ☐ Always

When you/your child are/is in your/your child's neighborhood do you/does your child feel safe?
☐ Yes ☐ No
In the past 6 months, have you/has your child seen any non-violent crime in your/their neighborhood, such as someone selling drugs or stealing?
☐ Yes ☐ No
In the past 6 months, have you/has your child seen any violent crimes taking place in your/their neighborhood, such as someone being beaten up?
☐ Yes ☐ No
In the past 6 months, have you/has your child known someone other than yourself/themselves who was a victim of a violent crime in your/their neighborhood?
☐ Yes ☐ No
In the past 6 months, have you/has your child been a victim of a violent crime in your/their neighborhood?
☐ Yes ☐ No
In the past 6 months, have you/has your child been bullied at school or in your/their neighborhood?
☐ Yes ☐ No
In the past 6 months, have you/has your child experienced on-line bullying or threats (cyber-bullying)?
☐ Yes ☐ No

VII. Brief Pediatric Symptom Checklist

These questions are about the person coming in for services today. (ADHD, Int., Ext.)
Self-administration for CHILDREN AGE 11 AND OLDER.

[IF COMPLETED BY YOUTH HIM/HERSELF]:

Please mark under the heading that best fits you	Never	Sometimes	Often
Fidgety/unable to sit still			
Feel sad/unhappy			
Daydream too much			
Refuse to share			
Do not understand other people's feelings			
Feel hopeless			
Have trouble concentrating			
Fight with other children			
Down on yourself			
Blame others for your troubles			
Seem to be having less fun			
Do not listen to rules			
Act as if driven by a motor			
Tease others			
Worry a lot			
Take things that do not belong to you			
Distract easily			

[IF COMPLETED BY CAREGIVER]

Please mark under the heading that best describes your child	Never	Sometimes	Often
Fidgety/unable to sit still			
Feels sad/unhappy			
Daydreams too much			
Refuses to share			
Does not understand other people's feelings			

Please mark under the heading that best describes your child	Never	Sometimes	Often
Feels hopeless			
Has trouble concentrating			
Fights with other children			
Is down on self			
Blames others for his/her troubles			
Seems to be having less fun			
Does not listen to rules			
Acts as if driven by a motor			
Teases others			
Worries a lot			
Takes things that do not belong to him/her			
Distracts easily			

VIII. Feelings/Well-Being

Do you/Does your child often worry about or feel like something bad might happen?

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

Are you/Is your child tense, stressed out, and/or have difficulty relaxing?

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

Over the past two weeks how often have you/has your child felt down, depressed, hopeless?

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

Over the past two weeks have you/has your child felt little interest or pleasure in doing things?

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

Over the past two weeks have you/has your child had thoughts that you/they would be better off dead or harming yourself/themselves in some way?

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

Have you/Has your child ever purposely hurt your/themselves without wanting to die?

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

Have you/Has your child ever seriously thought about other killing yourself/themselves?

☐ Yes ☐ No

Are you/Is your child having thoughts like that now?

☐ Yes ☐ No

Have you/Has your child ever tried to kill yourself/themselves?

☐ Yes ☐ No

Have you/Has your child ever seriously thought about killing someone else?

☐ Yes ☐ No

Are you/Is your child having thoughts like that now?

☐ Yes ☐ No

Have you/Has your child ever tried to kill someone else?

☐ Yes ☐ No

Over the last <u>two weeks</u>, how often have you/has your child been bothered by any of the following symptoms? For each symptom, check the box next to the answer that best describes how you/your child are/is feeling. (Self-administered ages 11-17)

1. Feeling down, depressed, or hopeless

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

2. Little interest or pleasure in doing things

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

3. Trouble falling or staying asleep, or sleeping too much
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
4. Poor appetite or overeating
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
5. Feeling tired or having little energy
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
6. Feeling bad about yourself/themselves -- or that you/they are a failure or have let yourself/themselves or your/their family down
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
7. Trouble concentrating on things, like schoolwork, reading or watching TV
☐ Not at all ☐ Several days ☐ More than half the days ☐ 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/your child have been moving around a lot more than usual?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
9. Thoughts that you/your child would be better off dead, or hurting yourself/themselves in some way
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
In the past year have you/has your child felt depressed or sad most days, even if you/your child felt okay sometimes?
☐ Yes ☐ No
If you/your child are experiencing any of the problems on this form, how difficult have these problems made it for you/them to do your/their work, take care of things at home or get along with other people?
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult
Has there been a time in the past month when you/your child have/has had serious thoughts about ending your/their life?
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult
Have you/Has your child EVER, in your/their WHOLE LIFE, tried to kill yourself/themselves or made a suicide attempt?
☐ Yes ☐ No

****If you/your child have had thoughts that you/they would be better off dead or of hurting yourself/themselves in some way, please discuss this with your/your child's Health Care Clinician, go to a hospital emergency room or call 911.**

Severity Score by office_____

IX. Safety/Injuries
Do you/Does your child always wear a seatbelt when driving and riding in the car, truck or van?
☐ Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ A lot
Do you/Does your child always wear helmets when roller blading, biking, motorcycling, skateboarding, riding an ATV, skiing, or snowboarding?
☐ Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ A lot
Do you/Does your child text, talk or surf the Internet on your cell phone while you/they are driving?
☐ Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ A lot
Is there someone at home, school or anywhere else who has made you/your child feel afraid, threatened you/them or hurt you/them?
☐ Yes ☐ No
Have you/ Has your child ever been physically, sexually, or emotionally abused?
☐ Yes ☐ No
In the past 12 months has your/your child's boyfriend/girlfriend ever hit, slapped, hurt you/them on purpose?
☐ Yes ☐ No
Have you/ Has your child ever carried a weapon (gun, knife, etc.) to protect yourself/themselves?
☐ Yes ☐ No
Have you/ Has your child ever been in foster care, group home(s), or been homeless?
☐ Yes ☐ No

Have you/Has your child ever been in jail or in a detention center?

☐ Yes ☐ No

Do you/Does your child use sunscreen or other protection from the sun when you/they are outdoors?

☐ Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ A lot

In the past 6 months, how many times have you/has your child:

Been out of your/their parents' or caregivers' control so that the police needed to get involved?

☐ None ☐ 1 time ☐ More than 1 time

Purposefully damaged or destroyed (other than fire) property that did not belong to you/them?

☐ None ☐ 1 time ☐ More than 1 time

Taken something from a store without paying for it?

☐ None ☐ 1 time ☐ More than 1 time

Hit someone or been in a physical fight?

☐ None ☐ 1 time ☐ More than 1 time

Gotten a ticket or citation for a traffic violation (driving too fast, driving through a red light, etc.]

☐ None ☐ 1 time ☐ More than 1 time

Do you/ Does your child have a gun/firearm in the home?

☐ Yes ☐ No

If yes, is it unloaded and locked up?

☐ Yes ☐ No

X. Health Behaviors/Substance Abuse

1. In the past few weeks, have you/has your child smoked cigarettes or used any form of tobacco (like chew, dip, cigars, hookah and/or e-cigarettes)?

☐ Yes ☐ No

2. Have you/Has your child ever been in a car driven by someone (including yourself) that was high or was using alcohol or drugs?

☐ Yes ☐ No

3. During the past 12 months, did you/your child:

a. Drink any alcohol (more than two sips)?

☐ Yes ☐ No

b. Smoke any marijuana or hashish?

☐ Yes ☐ No

c. Use anything else to get high (includes illegal drugs, over-the-counter and prescription drugs, and things you sniff or huff)?

☐ Yes ☐ No

4. If you/your child answered "yes" to question 3, please complete questions a through e below. If you/they answered "no", please go to question 5.

a. Do you/Does your child ever use drinks to RELAX, feel better about yourself/themselves or fit in?

☐ Yes ☐ No

b. Do you/Does your child ever use drugs or alcohol when you/your child is by your/themselves or ALONE?

☐ Yes ☐ No

c. Do you/Does your child ever FORGET things you/they did while using alcohol or drugs?

☐ Yes ☐ No

d. Does your/your child's FAMILY or FRIENDS ever tell you/your child to cut down on drinking or using drugs?

☐ Yes ☐ No

e. Have you/Has your child ever gotten into TROUBLE while using alcohol or drugs?

☐ Yes ☐ No

5. Does anyone in your/your child's home take opioids (OxyContin, Hydrocodone, Codeine) for an ongoing medical condition?

☐ Yes ☐ No

6. Do they lock their opioid medications in a medicine cabinet or other locked location?
☐ Yes ☐ No
7. Do you/Does your child have a smoke detector in your/their home?
☐ Yes ☐ No
8. Do you/Does your child have gas heating or appliances in your/their home?
☐ Yes ☐ No
9. Do you/Does your child have a carbon monoxide detector in your/their home?
☐ Yes ☐ No
10. Do you/Does your child have area rugs in your/their home?
☐ Yes ☐ No
11. When walking in your/your child's home, are the areas free from clutter?
☐ Yes ☐ No
12. Is your/your child's home free from pests such as roaches, ants and spiders?
☐ Yes ☐ No

XI. Activities of Daily Living and Instrumental Activities of Daily Living					
Please indicate your/your child's ability to do the activities in the table below. If you are/your child is receiving help for any of these, mark that as well.					
Function	**Independent**	**Need Help**	**Dependent**	**Cannot Do**	**Receiving Help**
Bathing					
Dressing					
Grooming					
Mouth care					
Toileting					
Transferring bed/chair					
Walking					
Climbing stairs					
Eating					
Shopping					
Cooking					
Managing medications					
Using phone book/looking up numbers					
Doing housework					
Doing laundry					
Driving or using public transportation					
Managing finances					

XII. Durable Medical Equipment (please check)			
	Have	**Want**	**Wish to discuss**
Air-fluidized beds and other support surfaces			
Bar in toilet/shower			
Blood sugar (glucose) test strips			
Blood sugar monitors			
Canes (however, white canes for the blind aren't covered)			
Commode chairs			
Continuous passive motion (CPM) machine			

	Have	Want	Wish to discuss
Crutches			
Eyeglasses/contacts			
Hearing aid or other hearing equipment			
Hospital beds			
Infusion pumps and supplies (when necessary to administer certain drugs)			
Manual wheelchairs and power mobility devices			
Nebulizers and nebulizer medications			
Oxygen equipment and accessories			
Patient lifts			
Shower bench			
Sleep apnea and Continuous Positive Airway Pressure (CPAP) devices and accessories			
Suction pumps			
Traction equipment			
Translation devices			
Walkers			
Wheelchair			

Do you/Does your child have other adaptive equipment that is not listed above?

☐ Yes ☐ No

If yes, please describe:

Do you/Does your child want other adaptive equipment that is not listed above?

☐ Yes ☐ No

If yes, please describe:

Do you/Does your child have a caregiver that comes into the home, because of a health care problem, to provide you/them with assistance?

☐ Yes ☐ No

If caregiver is from an agency, please put their name here:

If caregiver is a relative or friend, please put their name here:

Caregiver's (or agency's) phone number:

How many hours per day/week does your/your child's caregiver come into your/their home?

What does your/your child's caregiver do?

Do you/Does your child need more help than you/they are receiving?

☐ Yes ☐ No

If yes, please describe:

Action Plan

Personal Health Plan			
How involved would you/your child like to be in the planning and development of your/their behavioral/health care and treatment plan? Please check the best answer for your/their preference.			
☐ Not at all involved ☐ A little involved ☐ Somewhat involved ☐ Involved ☐ Very involved			
I plan/my child plans to improve myself/themselves and/or set goals in the following areas in order of their importance (priority):			
Area(s):	**What do I/does my child plan to do to improve this?**	**What barriers might get in the way of me/my child improving myself/themselves or meeting my/their goals?**	**How confident am I/is my child in achieving my/their goals?**
1.			☐ Not Confident ☐ A Little Confident ☐ Average Confidence ☐ Confident ☐ Very Confident
2.			☐ Not Confident ☐ A Little Confident ☐ Average Confidence ☐ Confident ☐ Very Confident
3.			☐ Not Confident ☐ A Little Confident ☐ Average Confidence ☐ Confident ☐ Very Confident
4.			☐ Not Confident ☐ A Little Confident ☐ Average Confidence ☐ Confident ☐ Very Confident
5.			☐ Not Confident ☐ A Little Confident ☐ Average Confidence ☐ Confident ☐ Very Confident

Special accommodations needed for visit (large room, extra time, etc.):
What needs to be done before we meet next?
Upcoming appointments and procedures:
Who needs to be at the next meeting?
Next Care Coordination appointment date:
What will we meet about?
Where will we meet?
What time?

Individual Member Backup and Disaster Preparedness Plan

I. Member Information		
Name		Date
Address		**City**
Zip Code	**Phone 1:**	**Phone 2:**

II. Backup Plan Definition
A backup plan is to assist you to find help in an emergency. It also can help you if your scheduled worker(s) cannot give you care, services, or supports. The plan must include:
• Who you will call, along with the services you need, and phone numbers. • Plans for service animals or pets. • Plans for disaster preparedness (this is what you would do if there were an emergency, e.g., fire, tornado, or other kind of natural disaster.)
If you live in an adult care home, the sections of the facility's Disaster and Emergency Preparedness Plan which mentions the residents will be included in your backup plan.
If there is an emergency, call 911.

III. Backup plan if worker(s) do not show up			
I will contact one of the people listed below if I need help (e.g., care coordinator provider, friends, family, previous workers, church members, other volunteers).			
Service	**Name**	**Days/times not available**	**Phone**
Care Coordinator			
Below is my plan in case of an emergency or if my service provider(s) do not show up and I am unable to reach one of the individuals listed above:			

IV. Disaster Preparedness Plan

I will develop and post a list of emergency contacts that my providers may refer to easily, if necessary (e.g., who to contact to assist in an emergency or to assist with decisions).

Name	Days/times not available	Phone	Will be able to assist with

Below is my plan in case of a natural disaster or emergency:

V. Necessary Tasks

I understand I may only get my critical needs met in an emergency.
Listed below is a current description of the necessary tasks that are essential to my health and welfare.

Evacuation plan:

Necessary items to take (as applicable):

☐ Medication	☐ Feeding tube supplies	☐ Name/contact information of providers
☐ Oxygen tank /concentrator	☐ Identification cards and valuable papers	☐ Nebulizer and attachments
☐ Wound care supplies	☐ Special food	☐ Clothing
☐ Catheters /supplies	☐ Purse/wallet	☐ Medical summary

VI. Coordinate Services

☐ **Durable Medical Equipment (DME) needs/provider/contact information:**

☐ **Transportation plan/contact information:**

☐ **Home Health Care agency:**

☐ **Pharmacy where I can get my medication:**

☐ **Care of service animals or pets:**

☐ **Ways to stay safe in case of a fire, flood, or any other natural disaster:**

IV. Other Support Contacts			
I will call the individuals listed below if my health or welfare is jeopardized by a dangerous or harmful situation.			
Name	**Phone**	**Address**	**Relationship (relative, doctor, TCM, other)**

- If I believe I am at risk of harm from abuse, neglect, or exploitation, I know that I should contact **Adult Protective Services at 1-866-654-3219**.

My care coordinator and I have talked about this plan. I have reviewed the plan and understand what I am supposed to do.

Member Signature	Date	EOR/Authorized Agent

Individualized Care Plan

I. Member Information		
Name		**Date**
Date of Birth	**Gender**	**Phone**
Medicaid ID#	**Eligibility start date**	**Eligibility end date**
NFLOC	**Eligibility start date**	**Eligibility end date**
Medicare ID#		
Level of Care Coordination	**Contact frequency**	**Last CNA date**
Care Coordinator		**Phone**

II. Contacts		
Legal representative/guardian	**Phone**	**Relationship to member**
Primary Care Provider		**Phone**
Behavioral Health Therapist		**Phone**
Care Team		**Phone**
Emergency Contact	**Phone**	**Relationship to member**
Other (please specify)		**Phone**
Persons authorized by the member to have access to health care information and to assist with healthcare related services and support		
Name	**Phone**	**Relationship to member**

III. Communication Needs	
Primary spoken language	**Translation services required**
Primary written language	**Communication equipment required**

IV. Health History (physical and behavioral)	
Issue	**Date of onset**

Disease Management Needs		
Disease	**Intervention**	**Member action**

Surgeries	
Surgery	**Date**

Hospitalizations/Emergency Department Utilization	
Issue	**Date**

Medications		
Medication	**Dose and frequency**	**Start date**

Allergies
Strengths
Barriers
Functional needs
Medical equipment in use
Medical equipment needed
Physical environment (be sure to explain any challenges)
Environmental modifications necessary to ensure health and safety

Treatment/Services							
Service	**Amount**	**Frequency**	**Scope**	**From**	**To**	**Medicaid**	**Medicare**

Back-up plan for situations when regularly scheduled providers/caregivers are not available
Current community resources and services
Needed community resources and services
Disaster preparedness plan
Member goals

V. Plan of Care	
Opportunity – gap in care (short-term; 0-3 months)	
Goal	
Intervention	
Progress status/outcome	
Date initiated	**Target date**

Opportunity – gap in care (long-term; 3-12 months+)	
Goal	
Intervention	
Progress status/outcome	
Date initiated	**Target date**

Opportunity – self-management	
Goal	
Intervention	
Progress status/outcome	
Date initiated	**Target date**

Future opportunities

VI. Member/Guardian Consent	
The member/guardian has acknowledged that this Individualized Care Plan has been developed in part with their personal participation, cooperation and input. The member/guardian has also reviewed this document with their Care Coordinator, and has consented to the contents and guidelines outlined in this Individualized Care Plan.	
Signature of Member/Guardian	**Date**
Care Coordinator	**Date**