STATE OF HAWAII
Long Term Services and Support (LTSS)
ADULT LTSS ASSESSMENT TOOL
18 years and older

SECTION A. ADMINISTRATIVE INFORMATION

A1. Member

a. Member Name
_____
Last First MI

b. Date of Birth
/ /

c. Medicaid ID#

A2. Assessment

a. Reason for Assessment
- ☐ 1. Annual Assessment
- ☐ 2. Discharge Assessment
- ☐ 3. Initial Assessment
- ☐ 4. Reassessment due to a significant change in status
- ☐ 5. Other:

b. Assessment Reference Information
- ☐ 1. Date / /
- ☐ 2. Time __:__ ☐ AM ☐ PM
- ☐ 3. Location:
- ☐ 4. Identify any safety issues that a SC may encounter during the assessment.

c. Assessor
1. Assessor Name:
2. Title:

d. Additional Health Plan
1. Health Plan Name:
2. Subscriber Name:
3. Subscriber Number:

e. Medicare
1. Medicare ☐ Yes ☐ No
2. Medicare Advantage ☐ Yes ☐ No
3. Medicare ID #

f. Other Individual(s) at the Assessment
1. Is there a legal guardian, or representative assisting in the assessment? ☐ Yes ☐ No
2. Name of Individual: Relationship to Member:
3. Name of Individual: Relationship to Member:
4. Name of Individual: Relationship to Member:
5. Name of Individual: Relationship to Member:

A3. Legal Information

a. Legal Responsibility(ies)
- ☐ 1. Self
- ☐ 2. Legal Guardian
  Name:
- ☐ 3. Authorized Representative
  Name:
- ☐ 4. Healthcare Power of Attorney
  Name:
- ☐ 5. Other
  Name:

b. Advance Directives
1. Do you have an Advance Directive? ☐ Yes ☐ No
2. If yes, do you have a copy of the Advance Directive? ☐ Yes ☐ No
3. If no, would you like more information on Advance Directives? ☐ Yes ☐ No
4. Health Plan obtained copy for records ☐ Yes ☐ No
5. Do you have a Physician Orders for Life-Sustaining Treatment (POLST) ☐ Yes ☐ No
6. Location of POLST:

c. Comments:

SECTION B. DEMOGRAPHIC INFORMATION

B1. Demographics

a. Gender
- ☐ 1. Male
- ☐ 2. Female

b. Relationship Status
- ☐ 1. Single
- ☐ 2. Married
- ☐ 3. Divorced
- ☐ 4. Separated
- ☐ 5. Widowed
- ☐ 6. Other:

c. Ethnicity

- ☐ 1. African American
- ☐ 2. American Indian or Alaska Native
- ☐ 3. Asian
  - ☐ i. Cambodian
  - ☐ ii. Chinese
  - ☐ iii. Filipino
  - ☐ iv. Indian
  - ☐ v. Japanese
  - ☐ vi. Korean
  - ☐ vii. Laotian
  - ☐ viii. Vietnamese
  - ☐ ix. Other
- ☐ 4. Caucasian
- ☐ 5. Hispanic or Latino
- ☐ 6. Native Hawaiian or other Pacific Islander
  - ☐ i. Federated State of Micronesia
  - ☐ ii. Native Hawaiian
  - ☐ iii. Palauan
  - ☐ iv. Marshallese
  - ☐ v. Samoan
  - ☐ vii. Tongan
  - ☐ vii. Other
- ☐ 7. Other:

B2. Communication

a. Primary Means of Communication ☐ 1. Verbal ☐ 2. Non Verbal ☐ 3. Written ☐ 4. American Sign Language ☐ 5. Other:

b. Primary Spoken Language

- ☐ 1. English
- ☐ 2. Chinese (Cantonese)
- ☐ 3. Chinese (Mandarin)
- ☐ 4. Chuukese
- ☐ 5. Hawaiian
- ☐ 6. Ilocano
- ☐ 7. Japanese
- ☐ 8. Korean
- ☐ 9. Laotian
- ☐ 10. Marshallese
- ☐ 11. Palauan
- ☐ 12. Samoan
- ☐ 13. Spanish
- ☐ 14. Tagalog
- ☐ 15. Tongan
- ☐ 16. Vietnamese
- ☐ 17. Visayan
- ☐ 18. Other:

c. Interpretation

1. Do you need an interpreter? ☐ Yes ☐ No

d. Primary Written Language

- ☐ 1. English
- ☐ 2. Braille
- ☐ 3. Chinese (Cantonese)
- ☐ 4. Chinese (Mandarin)
- ☐ 5. Chuukese
- ☐ 6. Hawaiian
- ☐ 7. Ilocano
- ☐ 8. Japanese
- ☐ 9. Korean
- ☐ 10. Laotian
- ☐ 11. Large Format
- ☐ 12. Marshallese
- ☐ 13. Palauan
- ☐ 14. Samoan
- ☐ 15. Spanish
- ☐ 16. Tagalog
- ☐ 17. Tongan
- ☐ 18. Vietnamese
- ☐ 19. Visayan
- ☐ 20. Other:

e. Translation

1. Do you need a translator? ☐ Yes ☐ No

f. Education

1. Education Level:

g. Other Assistive Communication Device(s)

1. Other Assistive Communication Device(s):

h. Comments:

B3. Residence and Living Arrangements

a. Residence

- ☐ 1. Own Private house/apartment
- ☐ 2. Rent Private house/apartment/room
- ☐ 3. Houseless (with or without shelter)
- ☐ 4. Assisted Living Facility (ALF)
- ☐ 5. Adult Residential Care Home (ARCH)
- ☐ 6. Expanded Adult Residential Care Home (E-ARCH)
- ☐ 7. Foster Home
- ☐ 8. Community Care Foster Family Home (CCFFH)
- ☐ 9. Nursing Facility (NF)
- ☐ 10. Rehabilitation hospital/unit
- ☐ 11. Psychiatric hospital/unit
- ☐ 12. Acute care hospital
- ☐ 13. Other, specify.

b. Living Arrangement

- ☐ 1. Alone
- ☐ 2. With spouse/partner only
- ☐ 3. With spouse/partner and other(s)
- ☐ 4. With child (not spouse/partner)
- ☐ 5. With parent(s)/guardian(s)
- ☐ 6. With sibling(s)
- ☐ 7. With other relative(s)
- ☐ 8. With non-relative(s)
- ☐ 9. Other:

c. Comments:

SECTION. C MEDICAL INFORMATION

C1. Disease Diagnosis(es)

a. Disease Diagnosis(es)

List Disease Diagnosis(es)	ICD Code	Date of Onset
		/ /
		/ /
		/ /
		/ /
		/ /

C2. Medications

a. Medications

1. Do you take any medications, e.g., prescribed medications, vitamins, supplements, herbal or OTC medications?
   ☐ Yes ☐ No
2. List Current Medications

Medication Name	Indication	Dose	Route	Frequency	Prescribing Physician/Provider	Compliant	Comments
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	

C3. Treatments and Therap(ies)

a. List Treatment(s) and Therapy(ies)

Treatment/Therapy	Prescribing Physician/Provider	Provider/Agency	Frequency	Comments

C4. Medical Equipment and Supplies

a. List Medical Equipment and Supplies

Medical Equipment and Supplies	Type/Description	Prescribing Physician/Provider	Indicate Rent or Own	Vendor and Phone Number	Comments
			☐ Rent ☐ Own		
			☐ Rent ☐ Own		
			☐ Rent ☐ Own		
			☐ Rent ☐ Own		
			☐ Rent ☐ Own		

C5. HCBS Services

a. List HCBS Services

HCBS Service	Provider/Agency	Frequency	Comments

C6. Institutional Services

a. List Institutional Services

Institutional Service	Provider	Comments

C7. Physician(s) and Provider(s)

a. Physician(s) and Provider(s)

List Physician(s)/Provider(s) Name	Specialty	Address	Phone Number	Fax Number

C8. Utilization of Hospital, Emergency Room, and Physician Services

Services	Date	Reason
a. LAST Inpatient Acute Hospitalization	/ /	
b. LAST Emergency Room visit (not counting overnight stay)	/ /	
c. LAST Physician (or Provider, Practitioner, Authorized Assistant) visit	/ /	

d. Comments:

C9. State Programs

*****Do not complete for NF/CCFH/E-ARCH*****

a. Other State Program(s)

1. Are you currently receiving services from other State Program(s)? ☐ Yes ☐ No
2. Identify State Program(s)

	State Program	Contact Name	Phone Number	Number of Service Hours per week
☐	DOE/Special Education			
☐	DOE/Physical, Occupational or Speech Therapy			
☐	DOH/CAMHD			
☐	DOH/AMHD			
☐	DOH/DDD			
☐	DHS/CWS			
☐	DHS/APS			
☐	Other:			

b. Comments:

C10. Prevention

a. Preventative Screening(s)

1. Blood Pressure measured in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
2. Breast Cancer screening in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
3. Cervical Cancer screening in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
4. Colorectal screening in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
5. Osteoporosis in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
6. Prostate Cancer screening in the LAST 2 YEARS ☐ Yes ☐ No ☐ Unknown ☐ N/A

7. Total Cholesterol measured in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
8. Tuberculin (TB) Skin testing, PPD or 2 Step PPD in the LAST YEAR ☐ Yes ☐ No ☐ Unknown ☐ N/A
9. TB Results Negative/Positive ☐ Negative ☐ Positive
10. Date of last TB Chest X-ray / /
11. Weight/Height measured in the LAST YEAR ☐ Yes ☐ No
12. Well member visit/EPSDT screening (18 to 20 years) in the LAST YEAR ☐ Yes ☐ No

b. Comments:

C11. Immunizations

a. Immunizations
1. Are your immunizations up to date? ☐ Yes ☐ No ☐ Unknown
2. Date of Pneumococcal Vaccination / /
3. Date of LAST Influenza Vaccination / /

b. Comments:

C12. Personal Beliefs

a. Personal Beliefs
1. Do you have any beliefs and/or concerns that may affect your acceptance of health care assistance, treatments, or procedures? ☐ Yes ☐ No
2. If yes, explain:

b. Comments:

SECTION D. PERSON CENTERED INFORMATION

D1. Personal Interview

a. Personal Interview
1. Describe a "good day" for you.
2. Describe a "bad day" for you.
3. Describe ongoing responsibilities that you have to take care of.
4. What are your strengths and accomplishments?
5. What are you needs and concerns?

	6. Describe your life now.	7. Describe what you want in life.
Home/Family		
Recreation /Fun/Relaxation		
Community Involvement/ Social/Religious/Culture		

8. Do you have any specific end of life wishes or arrangements? ☐ Yes ☐ No
9. If yes, describe.

b. Comments:

D2. Finances

*****Do not complete for NF/CCFH/E-ARCH*****

a. Finances
1. Are you able to pay for your major monthly expenses? ☐ Yes ☐ No
2. If no, explain.
3. Are you receiving financial assistance? ☐ Yes ☐ No
4. Are you receiving SNAP? ☐ Yes ☐ No

b. Comments:

D3. Social Supports

*****Do not complete for NF/CCFH/E-ARCH*****

a. Social Supports
1. Family and/or friends living in the SAME residence

Name	Age	Relationship	Cell Phone	Day/Hours NOT available	Type of help	# of hours helped in LAST 7 days	Paid	Employed	Employer	Work hours/ week
							☐ Yes ☐ No	☐ Yes ☐ No		
							☐ Yes ☐ No	☐ Yes ☐ No		
							☐ Yes ☐ No	☐ Yes ☐ No		

2. Family and/or friends NOT living in the same residence and providing support to member

Name	Age	Relationship	Cell Phone	Day/Hours available	Type of help	# of hours helped in LAST 7 days	Paid	Employed	Employer	Work hours/ week
							☐ Yes ☐ No	☐ Yes ☐ No		
							☐ Yes ☐ No	☐ Yes ☐ No		
							☐ Yes ☐ No	☐ Yes ☐ No		

3. Strong and supportive relationship with family? ☐ Yes ☐ No

b. Comments:

D4. Primary Caregiver

*****Do not complete for NF/CCFH/E-ARCH*****

a. Primary Caregiver Status

1. Describe your feelings on being a primary caregiver, are you ok?
2. Describe how you take care of yourself.
3. Rate your overall general health and psychological well-being
   - ☐ i. Good
   - ☐ ii. Fair
   - ☐ iii. Poor
4. Do you need help caring for member? ☐ Yes ☐ No
5. At what point do you feel you will not be able to care for member and what happens then?
6. Are there any social issues in the home that concerns you? ☐ Yes ☐ No
7. If yes, explain.
8. Do you have any other caregiving demands or responsibilities? ☐ Yes ☐ No
9. If yes, explain.

b. Comments:

SECTION E. GENERAL HEALTH

E1. Vision, Hearing, Speech, Expression, and Comprehension

a. Vision

1. Visual impairment ☐ Yes ☐ No
   Describe:
2. Has/Uses corrective lenses or appliances
   - i. Glasses ☐ Yes ☐ No
   - ii. Contacts ☐ Yes ☐ No
3. Ability to see in adequate light with corrective lenses or appliances
   - ☐ i. Adequate
   - ☐ ii. Minimal difficulty
   - ☐ iii. Moderate difficulty
   - ☐ iv. Severe difficulty
4. Date of LAST eye exam / /

b. Hearing

1. Hearing impairment ☐ Yes ☐ No
   Describe:
2. Has/Uses hearing aids or appliances
   ☐ Yes ☐ No
3. Ability to hear with hearing aid or appliances
   - ☐ i. Adequate
   - ☐ ii. Minimal difficulty
   - ☐ iii. Moderate difficulty
   - ☐ iv. Severe difficulty
4. Date of LAST hearing exam / /

c. Speech

1. Speech pattern

d. Expression

1. Ability to verbally express ideas

e. Comprehension

1. Ability to understand others

☐ i. Coherent ☐ ii. Incoherent ☐ iii. No speech 2. Date of LAST speech evaluation / /	☐ i. Understood ☐ ii. Usually understood ☐ iii. Sometimes understood ☐ iv. Rarely or never understood	☐ i. Understands ☐ ii. Usually understands ☐ iii. Sometimes understands ☐ iv. Rarely or never understands
f. Comments:		

E2. Cognition

a. Repetition 1. Ability to repeat _____ (object), _____ (animal), and _____ (number) ☐ i. None ☐ ii. One Correct ☐ iii. Two Correct ☐ iv. Three Correct	b. Orientation 1. Able to report correct year ☐ Correct ☐ Incorrect 2. Able to report correct month ☐ Correct ☐ Incorrect 3. Able to report correct day of week ☐ Correct ☐ Incorrect 4. Able to report current president of the United States ☐ Correct ☐ Incorrect	c. Recall 1. Ability to recall _____ (object), _____ (animal), and _____ (number) ☐ i. None ☐ ii. One Correct ☐ iii. Two Correct ☐ iv. Three Correct
d. Score:	e. Comments:	

E3. Mood, Behavior, and Psychological Well Being

Note: Disease management may be appropriate for member that has been previously diagnosed. If member does not have a behavioral health diagnosis, SC should refer member to PCP for further evaluation.

a. Depression (PHQ-9 Foundation)
Over the LAST 2 WEEKS , how often have you been bothered by any of the following problems:

	None	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

b. Score

c. Coping Skills
1. Do you have difficulty at work, caring for things at home, or getting along with people? ☐ Yes ☐ No

d. Anger
1. Do you get angry easily? ☐ Yes ☐ No
2. Have you ever felt persistent anger with yourself or others? ☐ Yes ☐ No
3. If yes, describe what happens when you get angry.

e. Anxiety
1. Do you get anxious easily or worry excessively? ☐ Yes ☐ No
2. Do you suffer from panic attacks? ☐ Yes ☐ No

3. Do you ever feel like something terrible is going to happen?	☐ Yes ☐ No
f. Behavior	
1. Have you been wandering?	☐ Yes ☐ No
2. Have you been verbally abusive to yourself and/or others?	☐ Yes ☐ No
3. Have you been physically abusive to yourself and/or others ?	☐ Yes ☐ No
4. Have you been socially inappropriate or displayed disruptive behaviors?	☐ Yes ☐ No
5. Have you been resisting caregiving?	☐ Yes ☐ No
g. Social Relationships	
1. Have you ever had conflict or anger with family or friends?	☐ Yes ☐ No
2. If yes, explain.	
3. Have you ever felt fearful of a family member or close acquaintance?	☐ Yes ☐ No
4. If yes, explain.	
5. Have you ever felt neglected, abused, or mistreated?	☐ Yes ☐ No
6. If yes, explain.	
h. Major Life Stressor(s)	
1. Have you had any recent major life stressor(s)?	☐ Yes ☐ No
2. If yes, explain.	
i. Comments:	

E4. Functional Status

a. Instrumental Activities of Daily Living (IADLs)	**Independent**	**Minimal**	**Moderate**	Total
1. Routine house cleaning	☐	☐	☐	☐
2. Laundry	☐	☐	☐	☐
3. Shopping and Errands	☐	☐	☐	☐
4. Meal Preparation	☐	☐	☐	☐
b. Activities of Daily Living (ADLs)	**Independent**	**Minimal**	**Moderate**	Total
1. Eating/Feeding	☐	☐	☐	☐
2. Bathing	☐	☐	☐	☐
3. Dressing upper body	☐	☐	☐	☐
4. Dressing lower body	☐	☐	☐	☐
5. Grooming/Personal hygiene	☐	☐	☐	☐
6. Toileting	☐	☐	☐	☐
7. Walks with or without assistive device Identify assistive device(s):	☐	☐	☐	☐
8. Ambulation/Locomotion	☐	☐	☐	☐
9. Do you have difficulty accessing areas of your house? ☐ Yes ☐ No	If yes, explain.			
10. Transfers	☐	☐	☐	☐
11. Medication assistance	☐	☐	☐	☐

c. Activity and Mobility

1. Do you exercise or engage in moderate physical activity?	☐ Yes ☐ No
2. How many days per week do you exercise?	
3. How many total hours per week?	
4. Are there any physical limitations and/or environmental barriers that make it difficult for you to exercise or perform activities?	☐ Yes ☐ No
5. If yes, explain.	
6. Do you feel that you are capable of increasing physical activity?	☐ Yes ☐ No
7. If yes or no, explain.	
d. Comments:	

E5. Health Condition

a. Vitals

1. Temperature: _____ F
   i. Mode:
2. Pulse: _____ bpm
   i. Mode:
3. Respirations: _____ per min
4. Oxygen Saturation: _____%
   i. Mode:
5. Blood Pressure: _____/_____
   i. Location:
   ii. Position:
   iii. Usual blood pressure range:
   - / -

b. Allergies

1. Allergies: ☐ Yes ☐ No
2. Specify.

c. Fall History

1. Fall(s) within the last 30 DAYS:
   ☐ Yes ☐ No
2. Fall(s) within the past 31-90 DAYS: ☐ Yes ☐ No

d. Pain

1. Communication of Pain:
   ☐ i. Member is verbal and able to answer.
   ☐ ii. Member is non-verbal and unable to answer.
   ☐ iii. Caregiver/Authorized Representative is answering based on observation.
2. Current pain ☐ Yes ☐ No
3. Location:
4. Type:
5. Frequency:
6. Intensity:
   ☐ i. Numeric Rating Scale, OR
   ☐ ii. FACES Pain Rating Scale
7. Break though pain: ☐ Yes ☐ No
8. Pain management:

e. Substance Use **(***Do not complete for NF/CCFH/E-ARCH***)**

1. Tobacco
   i. Do you use any tobacco products? ☐ Yes ☐ No
   ii. How often and how many?
   iii. Does the amount you smoke present any problems for you? ☐ Yes ☐ No
   iv. If yes, are you interested or willing to quit? ☐ Yes ☐ No
2. Alcohol
   i. Do you drink any alcohol products? ☐ Yes ☐ No
   ii. How often and how many?
   iii. Does the amount you drink present any problems for you? ☐ Yes ☐ No
   iv. If yes, are you interested or willing to quit? ☐ Yes ☐ No
3. Other Substance
   i. Do you use any other substance(s)? ☐ Yes ☐ No
   ii. What substance(s)?
   iii. How often and how much?
   iv. Does the amount present any problems for you? ☐ Yes ☐ No
   v. If yes, are you interested or willing to quit? ☐ Yes ☐ No
3. Have you received treatment for tobacco, alcohol, and/or substance abuse? ☐ Yes ☐ No

f. Comments:

E6. Nutrition

a. Height, Weight, and Body Mass Index (BMI)

1. Height _____ feet _____ inches
   i. Date of height measurement:
   / /
2. Weight _____lbs
   i. Date of weight measurement:

b. Dental

1. Do you have any broken, fragmented, loose, or non-intact natural teeth?
   ☐ Yes ☐ No
2. Do you have/use dentures?
   ☐ Yes ☐ No

/ / 3. BMI: _____ i. Date BMI calculated: / /	3. Are you currently experiencing any tooth aches or pain? ☐ Yes ☐ No 4. Date of LAST Dental Exam: / /

c. Weight Loss or Gain

1. Describe the foods or meals that you normally eat.
2. Has a physician or provider recommended a special diet for you? ☐ Yes ☐ No
3. If yes, explain.
4. Has a physician or provider counseled you for your weight? ☐ Yes ☐ No
5. If yes, physician or provider counseled you for weight loss or weight gain? ☐ Loss ☐ Gain
6. Is there a plan for managing your weight? ☐ Yes ☐ No
7. If yes, describe plan.

d. Swallowing

1. Have you ever experienced dry mouth? ☐ Yes ☐ No
2. Do you have difficulty chewing and/or swallowing? ☐ Yes ☐ No
3. If yes, did you have a swallow evaluation? ☐ Yes ☐ No
4. Date of swallow evaluation
5. Do you hold food in your mouth/cheek instead of swallowing? ☐ Yes ☐ No
6. Do you cough or choke during meals or when swallowing medications? ☐ Yes ☐ No

e. Mode of Nutritional Intake

1. Are you able to eat by mouth? ☐ Yes ☐ No
2. Dietary Modifications
   - ☐ i. Normal
   - ☐ ii. Minced
   - ☐ iii. Pureed solids
   - ☐ iv. Thickened liquid
3. Do you require enteral feedings? ☐ Yes ☐ No
   - ☐ i. Nasogastric (NG) Tube
   - ☐ ii. Gastrostomy Tube (GT)
   - ☐ iii. Gastrojejunostomy (G/J) Tube
4. Do you require parenteral feedings? ☐ Yes ☐ No
   - ☐ i. Total Parenteral Nutrition (TPN)
   - ☐ ii. Other, parenteral feeding:

f. Comments:

E7. Continence

a. Continence

1. Bladder Continence
   - ☐ 1. Continent
   - ☐ 2. Control with catheter or ostomy
   - ☐ 3. Incontinent
2. Bowel Continence
   - ☐ 1. Continent
   - ☐ 2. Control with ostomy
   - ☐ 3. Incontinent

b. Do you use incontinence products? ☐ Yes ☐ No

c. Comments:

E8. Skin

a. Skin

1. Do you have any history of skin breakdown or pressure sores? ☐ Yes ☐ No
2. Do you currently have any skin break down, tears, or open sores? ☐ Yes ☐ No
3. Do you have any blood, drainage, or odor from a wound? ☐ Yes ☐ No
4. Describe the wound(s) and location(s).

b. Comments:

E9. Musculoskeletal

a. Bones, Muscles, or Joints

1. Do you have any history of bone, muscle, or joint abnormalities or complications? ☐ Yes ☐ No
2. Do you currently have any bone, muscle, or joint abnormalities or complications? ☐ Yes ☐ No
3. Describe your bone, muscle, or joint abnormalities or complications.

4. Have you ever had a bone, muscle, or joint surgery or procedure? ☐ Yes ☐ No
5. Date of Surgery/Procedure and Type.
   Date: / / Type:

b. Comments:

E10. Pregnant Female **(Complete this section if member is a pregnant female)**

*****Do not complete for NF/CCFH/E-ARCH*****

a. Pregnant Female Only

1. Expected Date of Delivery / /
2. Date of Last Menstrual Period / /
3. Are you receiving prenatal care? ☐ Yes ☐ No
4. Date of First Prenatal Visit / /
5. Date of Most Recent Prenatal Visit / /
6. Identify your prenatal care provider(s)
   - ☐ i. OB/GYN
   - ☐ ii. Midwife
   - ☐ iii. Other
7. How do you get to your scheduled appointments?
8. Total number of pregnancies:
9. Total number of births:
10. Any history of pregnancy/delivery complications? ☐ Yes ☐ No
11. If yes, explain.
12. Any current complications or is considered a high risk pregnancy? ☐ Yes ☐ No
13. If yes, explain.
14. What are your plans for delivery?
15. What are your plans after delivery?
16. Are you planning on breast feeding? ☐ Yes ☐ No
17. Are there other help after delivery? ☐ Yes ☐ No
18. If yes, explain.
19. Do you have plans for use of birth control after delivery? ☐ Yes ☐ No ☐ Unknown

b. Comments:

SECTION F. DISEASE SPECIFIC QUESTIONS

Instructions: Complete disease specific questions for those that have been identified in Section C1. Disease Diagnosis(es). SC will ask relevant questions appropriate to the member to gather information for SP.

F1. Asthma

a. Asthma

1. Briefly describe your current respiratory symptoms.
2. Are your symptoms getting better or worse in the last 12 months?
3. Do you use a peak flow meter? ☐ Yes ☐ No
4. How often do you use a peak flow meter?
5. Do you have a rescue inhaler? ☐ Yes ☐ No
6. How often do you use your rescue inhaler?
7. Do you use a nebulizer? ☐ Yes ☐ No
8. How often do you use your nebulizer?
9. Do you know what triggers your respiratory condition? ☐ Yes ☐ No
10. List your respiratory triggers.
11. Are you having difficulty sleeping at night due to respiratory symptoms? ☐ Yes ☐ No
12. Do you have difficulty performing activities of daily living (ADLs) due to respiratory symptoms? ☐ Yes ☐ No
13. If yes, do you receive help from family or is there a plan in place for managing your respiratory condition? ☐ Yes ☐ No

14. Explain your plan.

b. Comments:

F2. Cancer

a. Cancer

1. Are you currently being treated for cancer? ☐ Yes ☐ No
2. Type of Cancer.
3. Describe your current status.

b. Comments:

F3. Chronic Obstructive Pulmonary Disorder (COPD)

a. COPD

1. Briefly describe your current respiratory symptoms.
2. Are your symptoms getting better or worse in the last 12 months?
3. Do you use a peak flow meter? ☐ Yes ☐ No
4. How often do you use a peak flow meter?
5. Do you have a rescue inhaler? ☐ Yes ☐ No
6. How often do you use your rescue inhaler?
7. Do you use a nebulizer? ☐ Yes ☐ No
8. How often do you use your nebulizer?
9. Do you know what triggers your respiratory condition? ☐ Yes ☐ No
10. List your respiratory triggers.
11. Are you having difficulty sleeping at night due to respiratory symptoms? ☐ Yes ☐ No
12. Do you have difficulty performing activities of daily living (ADLs) due to respiratory symptoms? ☐ Yes ☐ No
13. If yes, do you receive help from family or is there a plan in place for managing your respiratory condition? ☐ Yes ☐ No
14. Explain your plan.
15. Do you use supplemental oxygen? ☐ Yes ☐ No
16. Oxygen Flow rate _____ LPM
17. Mode of oxygen delivery.

b. Comments:

F4. Diabetes

a. Diabetes

1. Briefly describe your current symptoms related to your diabetes.
2. Do you currently monitor your blood sugar levels? ☐ Yes ☐ No
3. How often is blood sugar being monitored?
4. What is your usual blood sugar range? _____-_____
5. What is your Glycohemoglobin or A1C level?
6. Has your doctor set a goal for your blood sugar range? ☐ Yes ☐ No
7. What is your doctor's recommended blood sugar range? _____-_____
8. Is there a plan in place for managing blood sugar levels? ☐ Yes ☐ No
9. If yes, explain.
10. Are you on insulin? ☐ Yes ☐ No
11. If yes, how do you administer your insulin, e.g., Injections, pump.
12. Do you sense when your blood sugar levels are low? ☐ Yes ☐ No
13. If yes, what are your symptoms?
14. Do you sense when your blood sugar levels are high? ☐ Yes ☐ No
15. If yes, what are your symptoms?
16. How do you manage your low blood sugar levels?
17. Do you have blood pressure, heart, kidney or circulatory problems? ☐ Yes ☐ No

18. If yes, explain.
19. Have you had an eye exam in the last 12 months? ☐ Yes ☐ No
20. Do you regularly check your feet for any open cuts, sores, swelling, tingling or discoloration? ☐ Yes ☐ No
21. Are your feet regularly checked by a doctor? ☐ Yes ☐ No
22. Do you have any amputations? ☐ Yes ☐ No
23. If yes, describe location(s).

b. Comments:

F5. End Stage Renal Disease (ESRD)

a. ESRD

1. When were you diagnosed with renal failure? / /
2. Are you currently receiving dialysis? If Yes, complete the following questions: ☐ Yes ☐ No
   i. Facility Name:
   ii. Location:
   iii. Telephone:
3. What type of dialysis is currently being used?
   ☐ i. Peritoneal
   ☐ ii. Hemodialysis
   ☐ iii. Other:
4. If peritoneal, who is assisting with your dialysis?
5. Dialysis frequency:
   ☐ i. Daily
   ☐ ii. Three times per week
   ☐ iii. Other:
6. Current access type for dialysis:
   ☐ i. AV Fistula
   ☐ ii. AV Graft
   ☐ iii. Vas Cath
7. Site most used:
   ☐ i. AV Fistula
   ☐ ii. AV Graft
   ☐ iii.Vas Cath
8. Have you missed 1 or more dialysis appointments in the last 30 days? ☐ Yes ☐ No
9. If yes, explain.
10. How do you get to your dialysis appointments?
11. Do you have help after your dialysis treatments?
12. Do you experience any problem(s) with your dialysis treatments? ☐ Yes ☐ No
13. If yes, explain.

b. Comments:

F6. Heart Disease

a. Heart disease

1. Do you have a heart condition? ☐ Yes ☐ No
   If yes, explain.
2. Have you had any heart surgeries? ☐ Yes ☐ No
3. If yes, what are the type(s) and dates of your heart procedure(s), e.g., valve surgery, catheterization.
   Heart Procedure: Date: / /
   Heart Procedure: Date: / /
4. Have you experienced any of the following: (Select all that apply)
   ☐ i. Palpitations (feels like butterflies, pounding, skipping a beat, racing)
   ☐ ii. Faster than normal heart rate (tachycardia)
   ☐ iii. Slower than normal heart rate (bradycardia)

- ☐ iv. Missing or skipping a heartbeat (irregular heart rhythm)
- ☐ v. Swelling below the knee or feet
- ☐ vi. Dizziness or feel like passing out (syncope)
- ☐ vii. Chest pain relieved with rest
- ☐ viii. Stroke

5. Do you get tired easily when walking short distances or walking up or down stairs? ☐ Yes ☐ No
6. How do you know that your heart condition is getting worse (i.e., weight gain, shortness of breath, swelling of lower extremities, facial droop, aphasia, angina, lightheadedness, etc.)
7. Do you regularly check your weight? ☐ Yes ☐ No
8. Do you regularly check your blood pressure? ☐ Yes ☐ No
9. Do you regularly check your pulse? ☐ Yes ☐ No

b. Comments:

F7. Hepatitis B/C

a. Hepatitis B/C

1. Briefly describe your current symptoms related to your condition.
2. Are you experiencing any side effects from the medications? ☐ Yes ☐ No
3. Do you have any help? ☐ Yes ☐ No
4. Do you need more help? ☐ Yes ☐ No
5. If no, do you anticipate needing help in the future? ☐ Yes ☐ No
6. Are you able to travel to scheduled doctor appointments? ☐ Yes ☐ No

b. Comments:

F8. High Blood Pressure

a. High blood pressure

1. Briefly describe your current symptoms related to your high blood pressure.
2. Do you currently monitor your blood pressure levels? ☐ Yes ☐ No
3. How often is blood pressure being monitored?
4. Has your doctor set a goal for your blood pressure range? ☐ Yes ☐ No
5. What is your doctor's recommended blood pressure range _____-_____
6. Is there a plan in place for managing blood pressure? ☐ Yes ☐ No
7. If yes, explain.
8. Do you have high blood sugar, kidney or circulatory problems? ☐ Yes ☐ No
9. If yes, explain.
10. List your current symptoms that would indicate that your high blood pressure is getting worse (i.e., chest pressure/discomfort, shortness of breath, headache etc.)
11. Are you able to list your symptoms? ☐ Yes ☐ No

b. Comments:

F9. HIV/AIDS

a. HIV/AIDS

1. Identify the current stage of your disease (HIV/AIDS)
   - ☐ i. Acute Infection
   - ☐ ii. Clinical latency (inactivity or dormancy)
   - ☐ iii. AIDS
   - ☐ iv. Unknown
2. Briefly describe your current symptoms related to your condition.
3. Experiencing any side effects from the medications? ☐ Yes ☐ No
4. Do you have any help? ☐ Yes ☐ No
5. Do you need further help? ☐ Yes ☐ No
6. If no, do you anticipate needing help in the future? ☐ Yes ☐ No
7. Are you able to travel to scheduled doctor appointments? ☐ Yes ☐ No

b. Comments:

F10. Seizures

a. Seizures

1. Describe what happens when you have seizure(s):
2. How often do you have seizures?
3. When did you last see a doctor about your seizures?
4. Have you had any change in your symptoms or seizures that your doctor is not aware of? ☐ Yes ☐ No
5. Are there things that can cause your seizures such as fever, bright lights, not taking medicines on time, and certain illnesses? ☐ Yes ☐ No
6. If yes, describe.
7. Do you usually know when a seizure is going to happen? ☐ Yes ☐ No
8. If yes, describe.
9. When was the last time you had a seizure?
10. How long does the seizure usually last?
11. Do others living with you know what to do to keep you safe when you have a seizure? ☐ Yes ☐ No
12. If yes, describe.
13. Have you been told by your doctor when to call 911? ☐ Yes ☐ No
14. If yes, describe.
15. Have others living with you been trained in CPR? ☐ Yes ☐ No

b. Comments:

F11. Shortness of Breath

a. Shortness of breath

1. How would you describe your shortness of breath, e.g., mild, moderate, severe.
2. When do you experience shortness of breath?
3. What relieves your shortness of breath?
4. Is there a plan in place for managing your shortness of breath? ☐ Yes ☐ No
5. If yes, explain.

b. Comments:

F12. Transplant

a. Transplant

1. Have you had a transplant? ☐ Yes ☐ No
2. What type of transplant?
3. Describe your current status.

b. Comments:

SECTION G. TRANSPORTATION

*****Do not complete for NF/CCFH/E-ARCH*****

a. Assessor Determination

1. Is the member alert and aware of surroundings? ☐ Yes ☐ No
2. Is the member able to understand and respond to verbal commands? ☐ Yes ☐ No

b. Transportation

1. Current Mode of Transportation (Select all that apply)
   - ☐ i. Drives own vehicle
   - ☐ ii. Family or friends
   - ☐ iii. Public transportation
     - ☐ a. Bus
     - ☐ b. Handi van

☐ iv. Van
- ☐ a. Curb to curb
- ☐ b. Door to door
- ☐ c. Gurney

☐ v. Taxi
☐ vi. Air Travel for specialist care
☐ vii. Other:

2. Are you able to use public transportation or can someone regularly transport you to obtain medical services? ☐ Yes ☐ No
3. If no, explain.
4. Are you able to ambulate without assistance (with or without device, includes wheelchair)? ☐ Yes ☐ No
5. Are you able to ambulate to the local bus stop? ☐ Yes ☐ No
6. Describe.
7. If wheelchair bound, are you able to self-propel to curb side for pick up? ☐ Yes ☐ No
8. If wheelchair bound, are you able to transfer in and out of vehicle without assistance? ☐ Yes ☐ No
9. If the member needs assistance, do you have an attendant? ☐ Yes ☐ No
10. Do you require any medical equipment when traveling? ☐ Yes ☐ No
11. If yes, list medical equipment (e.g., ventilator, suction machine, feeding pump, etc.)
12. Are you able to get to curb side alone (If No, select all that apply) ☐ Yes ☐ No

☐ i. No attendant
☐ ii. Attendant is unable to help member to curb side
☐ iii. Member is bedbound
☐ iv. Member is non ambulatory
☐ v. Member is unable to transfer or receive assistance

c. Comments:

SECTION H. HOME ENVIRONMENT

*****Do not complete for NF/CCFH/E-ARCH*****

a. Current Home

1. Where are you currently Living:(Select all that apply)
   - ☐ i. Own House
   - ☐ ii. Own Apartment
   - ☐ iii. Rented House
   - ☐ iv. Rented Apartment
   - ☐ v. Relative/Friend's House
   - ☐ vi. Public Housing
   - ☐ vii. Hawaiian Homestead
   - ☐ viii. Section 8
   - ☐ ix. Other:
2. Do you feel safe in your neighborhood? ☐ Yes ☐ No
3. Does the building have a secured lobby? ☐ Yes ☐ No ☐ NA
4. If yes, entry code and/or entry directions.
5. Is there an elevator in the building? ☐ Yes ☐ No ☐ NA
6. Is your home accessible to wheelchairs or other assistive devices? ☐ Yes ☐ No
7. Identify the accessible Locations: (Select all that apply)
   - ☐ i. Doorways
   - ☐ ii. Hallway
   - ☐ iii. Bathroom
   - ☐ iv. Exits

	Adequate	Inadequate	N/A	Comments
b. Exterior Assessment				
Walkways free of clutter	☐	☐	☐	
Ramps/handrails safe	☐	☐	☐	#Exits ☐ Accessible Locations
Stairs safe	☐	☐	☐	#steps Locations
Safe water source	☐	☐	☐	Water catchment
Other:	☐	☐	☐	

c. Interior Assessment				
Clear pathway to exit/entry	☐	☐	☐	
Sturdy floors (other structural)	☐	☐	☐	
Handrails safe	☐	☐	☐	
Stairs safe	☐	☐	☐	#steps Locations
Free of trash accumulation/Trash Disposal	☐	☐	☐	
Lighting	☐	☐	☐	
Tacked down rugs and carpets	☐	☐	☐	
Visible cords/electrical circuits safe	☐	☐	☐	
Telephone service and accessibility	☐	☐	☐	
Smoke/fire detector or fire extinguisher operational	☐	☐	☐	Locations
Grab bars/support structures	☐	☐	☐	Locations
Bathing/hand washing facilities	☐	☐	☐	☐ Hot water ☐ Running water
Food preparation areas clean	☐	☐	☐	
Cooking appliances safe	☐	☐	☐	☐ Stove ☐ Fridge ☐ Freezer ☐ Microwave
Food storage safe	☐	☐	☐	
Pets in house (cats, dogs, etc.) secured	☐	☐	☐	
Laundry	☐	☐	☐	☐ Washer ☐ Dryer
Insects/other pests or rodents	☐	☐	☐	
Smoke free house	☐	☐	☐	
Guns/weapons (locked/unlocked)	☐	☐	☐	
Sufficient space for equipment/supplies	☐	☐	☐	☐ Generator
Home ventilation	☐	☐	☐	☐ Too hot ☐ Too cold
Other:	☐	☐	☐	
d. Comments:				

SECTION I. EMERGENCY PLANNING

*****Do not complete for NF/CCFH/E-ARCH*****

a. Emergency Contact(s)

	Name	Relationship to member	Address	Phone number	Email address
1. Primary					
2. Secondary					

b. Emergency Plan

1. Describe your Fire Evacuation Plan (Attach floor plan).
2. Describe your Disaster Evacuation Plan.
3. Where is the nearest Emergency Shelter:
4. Describe your Power Outage Back up Plan/Equipment.
5. Location of your fuse box/circuit breaker.
6. Location of your water turn off valve.
7. Is your Individualized Emergency Back-up Plan Form completed? ☐ Yes ☐ No

c. Comments:

SECTION J. MEMBER NEEDS

J1. Treatments and Therapy Needs

a. List Treatment and Therapy Needs

Treatment/Therapy	Frequency	Comments

J2. Medical Equipment and Supply Needs

a. List Medical Equipment and Supply Needs

Medical Equipment/Supply	Type/Description	Comments

J3. HCBS Needs

a. List HCBS Service Needs

HCBS Service	Frequency	Comments

J4. Institutional Needs

a. List Institutional Needs

Institutional Service	Comments

J5. Referrals

a. Referrals

Service	Comments

SECTION K. EDUCATION

a. List Education

Education that was Provided	Education Needs	Comments

SECTION L. SUMMARY/ADDITIONAL INFORMATION

a. Goal: To document a brief summary of visit.

a. Instructions: Provide a brief summary of visit. Include additional information that affects the delivery of services i.e., any barriers and identify any needs that require follow up.

APPENDICES

Appendix A. Treatments and Therapies

1. BiPAP/CPAP
2. Catheter care
3. Chemotherapy
4. Chest physiotherapy
5. Cough Insufflator/Exsufflator*
6. Dialysis
7. Enteral Feeding*
8. Home Health
9. Hospice care
10. IV therapy*
11. Occupational therapy
12. Oxygen therapy
13. Palliative care
14. Personal Emergency Response System (PERS)
15. Physical therapy
16. Psychological therapy
17. Radiation
18. Respiratory therapy
19. Speech language therapy
20. Suctioning*
21. Tracheostomy care*
22. Transfusion
23. Ventilator care*
24. Wound care*

99. Other

Appendix B. Medical Equipment and Supplies

1. Bath chair/shower bench
2. BiPAP/CPAP
3. Cane
4. Catheter Supplies
5. Chest Vest
6. Commode
7. Cough Insufflator/Exsufflator*
8. Enteral Feeding Supplies*
9. Feeding Pump*
10. Grab bars
11. Hand held shower head
12. Hospital Bed
13. Incontinence supplies
14. Nebulizer*
15. Ostomy Supplies
16. Oxygen concentrator*
17. Oxygen tank*
18. Patient lift
19. Personal Emergency Response System (PERS)
20. Pulse oximeter*
21. Scooter
22. Specialty mattress
23. Stander
24. Suction machine*
25. Toilet Chair
26. Tracheostomy Supplies*
27. Transfer board
28. Walker
29. Wheelchair

99. Other

Appendix C. HCBS Services

1. Adult Day Care (ADC)
2. Adult Day Health (ADH)
3. Assisted Living Facility (ALF)
4. Community Care Management Agency (CCMA)
5. Counseling and Training (C&T)
6. Community Care Foster Family Home (CCFFH)
7. Expanded Adult Residential Care Home (E-ARCH)
8. Environmental Accessibility Adaptations (EAA)
9. Home Delivered Meals
10. Home Maintenance
11. Moving Assistance
12. Non-Medical Transportation
13. Personal Assistance Services – Level 1 (PA-1) -
14. Personal Assistance Services – Level II (PA-2) -
15. Personal Assistance-Level 2 Delegated (PA-2 Delegated)
16. Personal Emergency Response System (PERS)
17. Respite Care
18. Skilled (or Private Duty) Nursing (SN)
19. Specialized Medical Equipment and Supplies

99. Other

Appendix D. Institutional Services

1. Acute Waitlisted ICF/SNF
2. NF (ICF/SNF)
3. Sub-Acute Facility
4. Rehabilitation Center

Appendix E. Diseases

1. Asthma
2. Cancer
3. Chronic Obstructive Pulmonary Disorder (COPD)
4. Diabetes
5. End Stage Renal Disease (ESRD)
8. High Blood Pressure
9. HIV/AIDS
10. Seizures
11. Shortness of Breath
12. Transplant

6. Heart Disease 7. Hepatitis B/C	99. Other

Appendix F. Acronyms

1. **ADC** Adult Day Care	18. **EAA** Environmental Accessibilities Adaptations
2. **ADH** Adult Day Health	19. **E-ARCH** Expanded Adult Residential Care Home
3. **ADLs** Activities of Daily Living	20. **EPSDT** Early and Periodic Screening, Diagnosis, and Treatment
4. **ALF** Assisted Living Facility	21. **HCBS** Home and Community Based Services
5. **AMHD** Adult Mental Health Division	22. **IADLs** Instrumental Activities of Daily Living
6. **APS** Adult Protective Services	23. **ICF** Intermediate Care Facility
7. **ARCH** Adult Residential Care Home	24. **LTSS** Long-Term Services and Supports
8. **ASL** American Sign Language	25. **MQD** Med-QUEST Division
9. **BMI** Body Mass Index	26. **NF** Nursing Facility
10. **CAMHD** Child and Adolescent Mental Health Division	27. **PA** Personal Assistance
11. **CCFFH** Community Care Foster Family Home	**28. PERS** Personal Emergency Response System
12. **CCMA** Community Care Management Agency	29. **PCP** Primary Care Provider
13. **CWS** Child Welfare Services	30. **SC** Service Coordinator
14. **DDD** Developmental Disabilities Division	31. **SHCN** Special Health Care Needs
15. **DHS** Department of Human Services	32. **SN** Skilled Nursing (Private Duty)
16. **DOE** Department of Education	33. **SNAP** Supplemental Nutrition Assistance Program
17. **DOH** Department of Health	34. **SNF** Skilled Nursing Facility
	35. **SP** Service Plan