STATE OF HAWAII
Special Health Care Needs (SHCN)
CHILD REASSESSMENT TOOL
Up through 17 years old

Instructions: *Compile information from health plan records and address changes from previous assessment. Refer to CHILD LTSS ASSESSMENT INSTRUCTIONS for information on completing the appropriate sections. If there are no changes, check box "No Changes"*

SECTION A. ADMINISTRATIVE INFORMATION

A1. Member

a. Member Name	b. Date of Birth	c. Medicaid ID#
Last First MI	/ /	

A2. Assessment

a. Reason for Assessment
1. HCBS Reassessment
   - ☐ Three (3) months
   - ☐ Six (6) months
   - ☐ Nine (9) months
2. NF Reassessment
   - ☐ Six (6) months

b. Assessment Reference Date
- ☐ 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:

e. Individual(s) at the Assessment
1. Name of Individual: Relationship to Member:
2. Name of Individual: Relationship to Member:
3. Name of Individual: Relationship to Member:
4. Name of Individual: Relationship to Member:

A3. Legal Information ☐ No Changes

Comments:

SECTION B. DEMOGRAPHIC INFORMATION

Comments:

SECTION. C MEDICAL INFORMATION

C1. Disease Diagnosis(es) ☐ No Changes

a. Disease Diagnosis(es)

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

C2. Medications ☐ No Changes

a. Medications
1. Do you take any medications, i.e.., 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. Treatment(s) and Therapy(ies) ☐ No Changes

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

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

C4. Medical Equipment and Supplies ☐ No Changes

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. Physician(s) and Provider(s) ☐ No Changes

a. Physician(s) and Provider(s)

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

C6. Utilization of Hospital, Emergency Room, and Physician Services ☐ No Changes

Comments:

C7. State Programs ☐ No Changes

Comments:

SECTION D. PERSON CENTERED INFORMATION

Instructions: Compile information from health plan records and address changes from previous assessment. Refer to CHILD LTSS ASSESSMENT INSTRUCTIONS for information on completing the appropriate sections. If there are no changes, check box "No Changes"

D1. Parents/Primary Caregiver ☐ No Changes

a. Parents/Primary Caregiver Status

1. Describe your feelings, are you ok?
2. Describe how you take care of yourself.
3. Do you need help caring for member? ☐ Yes ☐ No
4. At what point do you feel you will not be able to care for member and what happens then?
5. Do you have other demands or responsibilities? ☐ Yes ☐ No
6. If yes, explain.

b. Comments:

SECTION E. GENERAL HEALTH

E1. Mood, Behavior, and Psychological Well Being ☐ No Changes

Note: If member scores 15 or higher on Pediatric Symptom Checklist or answers yes to questions b or c, SC should refer member to PCP or CAMHD for further evaluation.

a. How often has your child been affected by any of the following problems:

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	Never (0)	Sometimes (1)	Often (2)
1. Feels sad, unhappy	☐	☐	☐
2. Feels hopeless	☐	☐	☐
3. Dislikes themselves	☐	☐	☐
4. Worries a lot	☐	☐	☐
5. Seems to be having less fun	☐	☐	☐
6. Fidgety, unable to sit still	☐	☐	☐
7. Daydreams too much	☐	☐	☐
8. Distracted easily	☐	☐	☐
9. Has trouble concentrating	☐	☐	☐
10. Acts as if they have endless energy	☐	☐	☐
11. Fights with other children	☐	☐	☐
12. Does not listen to rules	☐	☐	☐
13. Does not care about others	☐	☐	☐
14. Teases others	☐	☐	☐
15. Blames others for his/her troubles	☐	☐	☐
16. Does not like to share	☐	☐	☐
17. Takes things that do not belong to him/her	☐	☐	☐

b. Score:

c.
1. Does your child have any emotional or behavioral problems for which she/he needs help? ☐ Yes ☐ No
2. If yes, please explain and place comments here.

d.
1. Has anything significant happened recently that impacts your child's life? ☐ Yes ☐ No
2. If yes, please identify and place comments here.

e. Comments:

E2. Health Condition ☐ No Changes

a. 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:

b. Comments:

E3. Pregnant Female (Assess only if applicable) ☐ No Changes

Comments:

SECTION F. TRANSPORTATION ☐ No Changes

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. Family vehicle
   - ☐ ii. Friend's vehicle
   - ☐ 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. Able to use public transportation or someone regularly transports you to medical services? ☐ Yes ☐ No
3. If no, explain.
4. Able to ambulate without assistance (with or without device, to include wheelchair)? ☐ Yes ☐ No
5. Able to ambulate to the local bus stop (both house and medical appointments)? ☐ Yes ☐ No
6. If no, explain.
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. Requires a nurse for medical appointments.
10. If the member needs assistance, do you have an attendant? ☐ Yes ☐ No
11. Does the member require any medical equipment when traveling? ☐ Yes ☐ No
12. If yes, list medical equipment (e.g., ventilator, suction machine, feeding pump, etc.)
13. Reason member is unable to get to curb side alone (Select all that apply)
    - ☐ i. Attendant is unable to help member to curb side
    - ☐ ii. Member is bedbound
    - ☐ iii. Member is non ambulatory
    - ☐ iv. Member is unable to transfer or receive assistance

c. Comments:

SECTION G. MEMBER NEEDS ☐ No Changes

Comments:

SECTION H. SUMMARY/ADDITIONAL INFORMATION ☐ No Changes

Document, at a minimum, the following:

1. Status of all items on the service plan
2. Changes for areas identified on this tool
3. Update on all disease specific conditions of the member
4. Any concerns related to home environment
5. Any changes related to emergency planning
6. Any reference to other service coordinator consultants (i.e., nurse or social worker)
7. Any other pertinent areas that SC identified upon reassessment