Enhanced Care Management (ECM) Comprehensive Assessment Members Under Age 21 (FORM H)

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MEMBER INFORMATION

Medi-Cal # CIN: (9 digits/letter) _____ Authorization #: _____

Child's First Name: _____ Child's Last Name: _____

Date of Birth: _____ Age: _____ Member's Phone Number: _____

Preferred written/spoken language: _____ Requires Interpreter: ◯ YES ◯ NO

Address: _____

Homeless: ◯ YES ◯ NO

Emergency Contact (Name/Phone#): _____

Relationship: _____ Has an Authorized Representative (AR): ◯ YES ◯ NO

Name (AR): _____ Relationship (AR): _____

Phone # (AR): _____

Pediatrician's Name/Primary Care Provider: _____

PCP Phone Number: _____

ECM PROVIDER INFORMATION

ECM Organization Name: _____

Lead Care Manager Name: _____ Phone Number: _____

Lead Care Manager Email Address: _____

Assessment completed with:

◯ Member ◯ Mother ◯ Father ◯ Other Authorized Representative
◯ Foster Parent ◯ Grandparent ◯ Other/Name (relationship) _____

Assessment Completed: ◯ InPerson ◯ Over the Phone ◯ Both (In Person and on the Phone)

Assessment Type: ◯ Initial ◯ Reassessment

Assessment Date(s): _____

CHILD AND YOUTH

Select all that apply:

- ◯ **HOMELESSNESS:** Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness
- ◯ **AVOIDABLE HOSPITAL OR EMERGENCY DEPARTMENT USE:** Children and Youth At Risk for Avoidable Hospital or ED Utilization
- ◯ **SERIOUS MENTAL HEALTH OR SUBSTANCE USE DISORDER:** Children and Youth with Serious Mental Health and/or SUD Needs
- ◯ **JUSTICE INVOLVED:** Children/Youth Transitioning from a Youth Correctional Facility
- ◯ **CCS OR CCS WHOLE CHILD MODEL:** Children/Youth Enrolled in California Children's Services (CCS) or CCS WCM with Additional Needs Beyond the CCS Condition
- ◯ **FOSTER CARE:** Children/Youth Involved in Child Welfare
- ◯ **BIRTH EQUITY:** Pregnant and Postpartum Individuals at Risk for Adverse Perinatal Outcomes

ENGAGEMENT PURPOSE/MEANING AND STRENGTHS

Ask at least 3 or more of these engagement questions:

◯ **How strongly do you agree with this statement? I lead a purposeful and meaningful life:**

◯ **Member:** ◯ Agree ◯ Disagree ◯ Don't know

◯ **AR:** ◯ Agree ◯ Disagree ◯ Don't know

◯ **Strengths:** What is something that you are good at or proud of?

◯ **Member:**

◯ **AR:**

◯ **Coping Skills:** When you feel sad or worried, what helps you feel better? What do you do for fun or to relax?

◯ **Member:**

◯ **AR:**

◯ **Problem-Solving Skills:** When you had a difficult situation in the past, what did you do?

◯ **Member:**

◯ **AR:**

◯ **Motivation:** What do you want to improve about your health? Why do you want to improve your health?

◯ **Member:**

◯ **AR:**

CULTURE

Does Member or AR have any cultural, religious and/or spiritual beliefs that are important to your family's health and wellness? ◯ YES ◯ NO

If yes, please explain:

HEALTH LITERACY

I would like to ask you about how you think you are managing your health conditions:

Does Member need help taking medications? If AR, do they need assistance administering medications?

◯ Yes ◯ No**(LTSS)**

Does Member or AR need help filling out health forms? ◯ Yes ◯ No**(LTSS)**

Does Member or AR need help answering questions during a doctor's visits? ◯ Yes ◯ No**(LTSS)**

How often does Member or AR have difficulty understand written information your health care provider (like a doctor, nurse, nurse practitioner) gives you?

◯ Always ◯ Often ◯ Sometimes ◯ Occasionally ◯ Never

Coordination of Care Needs and Referrals:

EMERGENCY DEPARTMENT VISITS OR HOSPITALIZATIONS

◯ Have you had any Emergency Department (ED) visit or hospitalizations (in the last 30 days)? ◯ Yes ◯ No

Have there been any hospitalizations in the last 6 months? ◯ 1 time ◯ 2 times ◯ 3 or more times

Reason for ED OR Hospital Admission:

HEALTH QUESTIONS

How long ago did the Member see their pediatrician/primary care doctor (PCP)?

◯ Less than 6 months ago ◯ More than 6 months ago ◯ More than 12 months ago

Are all immunizations up to date? ◯ Yes ◯ No

Date of last physical exam:

Date of last dental exam:

Date of last eye exam:

Coordination of Care Needs and Referrals:

PHYSICAL HEALTH

◯ **No Concerns Noted**

Has Member been told by a medical provider that they have any of the following?

◯ Autism
◯ Cancer
◯ Cerebral Palsy
◯ Cleft Palate/Cleft Lip
◯ Congenital Deformity
◯ Diabetes
◯ Developmental Delay
◯ Kidney Disease or Failure
◯ On Dialysis: ◯ Yes ◯ No
Which Dialysis Center:
◯ Ear Infections: ◯ Frequent ◯ Recurrent
◯ Epilepsy/Seizure Disorder
◯ Hearing Loss
◯ Heart Defects (ASD, VSD)
◯ Leukemia
◯ Prematurity (at birth)
◯ Respiratory Conditions (e.g., Asthma, Chronic Bronchitis, Pneumonia)
◯ Trauma/accident (causing brain injury, burns, severe wounds, impaired mobility)
◯ Vision Loss (e.g., glaucoma, retinopathy of prematurity, optic nerve hypoplasia)
◯ Other:

Coordination of Care Needs and Referrals:

MEDICATIONS

◯ **No Concerns Noted**

Over the past week, has the Member not taken medications as prescribed? ◯Yes ◯No

If yes, please describe what prevents you from (taking/administering) medication as prescribed.

PALLIATIVE CARE

- ◯ Doesnot meet Palliative Care Criteria
- ◯ Enrolled in Palliative Care Services
- ◯ Meets Criteria Needs Referral
- ◯ Declined Assistance with Referral

Palliative care consists of patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services and does not affect a member's eligibility to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.

PRIVATE DUTY NURSING (PDN)

- ◯ Doesnot meet Private Duty Nursing (PDN) Criteria
- ◯ Enrolled in Private Duty Nursing (PDN)
- ◯ MeetsCriteria Needs Referral
- ◯ Declined Assistance with Referral

PDN services are nursing services provided in a member's home by a registered nurse (RN) or licensed vocational nurse (LVN) for a member who requires more individual and continuous care than what would be available from a visiting nurse.

BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

◯ **No Concerns Noted**

Does the Member have behavioral or mental health issues, such as (check all that apply):

◯ ADHD/ADD
◯ Obsessive-Compulsive Disorder
◯ Anorexia/Bulimia/other eating disorder
◯ Stress/feeling overwhelmed
◯ Anxiety
◯ Substance Misuse/Alcohol Misuse
◯ Bipolar
◯ Smoke, Vape, or Chew Tobacco
◯ Depression
◯ Intellectual Disability
◯ Other:

Has the Member had any Emergency Department (ED) visits or inpatient stay the last 6 months due to their mental health condition? ◯ Yes ◯ No

Does the Member feel they ought to cut down on their drinking or drug use?
If Yes, go to next question ◯ Yes ◯ No

Would the Member like to talk with someone about their substance use, especially if they're thinking of quitting or cutting back? ◯ Yes ◯ No

Coordination of Care Needs and Referrals:

COGNITIVE FUNCTION

◯ **No Concerns Noted**

Has the Member had any changes in thinking, remembering, or making decisions? ◯ Yes ◯ No

In the past month, has the Member felt worried, scared, or confused that something may be wrong with their mind or memory? ◯ Yes ◯ No

Coordination of Care Needs and Referrals:

SAFETY

◯ **NoConcerns Noted**

Is Member afraid of anyone or is anyone hurting them? ◯Yes ◯No **(LTSS)**

If yes, please explain:

Is anyone using your money without your ok? ◯Yes ◯No **(LTSS)**

If yes, please explain:

Based on the following requirement, is the Member using an appropriate car seat?

Children **under 2 years** of age shall ride in the rear-facing car seat unless the child weighs 40 or more pounds or is 40 or more inches tall. Does Member have this specified car seat? ◯Yes ◯ No

Children **under the age of 8** must be secured in a car seat or booster seat in the back seat.
Does Member have this specified car seat? ◯Yes ◯No

Children who are **8 years of age OR have reached 4 feet 9 inches** in height may be secured by a booster seat, but at a minimum must be secured by a safety belt. Does Member have this specified car seat? ◯Yes ◯No

Passengers who are 16 years of age and over are subject to California's Mandatory Seat Belt Law
AR or Member aware of seat belt laws? ◯Yes ◯No

Coordination of Care Needs and Referrals:

ACTIVITIES OF DAILY LIVING

◯ **NoConcerns Noted**

Does the Member need help with any of the following tasks due to their medical condition, not because of age: ◯ Yes ◯ No **(LTSS)**

Does the Member need help with any of these actives? ◯Yes ◯No

Select all that apply

Getting dressed/putting on clothes	◯ Yes	◯ No
Taking a bath or shower	◯ Yes	◯ No
Getting to the bathroom/toilet	◯ Yes	◯ No
Brushing teeth/Brushing hair	◯ Yes	◯ No
Eating	◯ Yes	◯ No
Walking	◯ Yes	◯ No
Going up stairs	◯ Yes	◯ No
Getting out of bed or a chair	◯ Yes	◯ No

Other please explain

If yes, is Member getting all the help they need with these activities? ◯Yes ◯ No **(LTSS)**

Does Member have family members or others willing and able to help when needed? ◯Yes ◯No **(LTSS)**

Does Member ever think their caregiver has a hard time giving them all the help needed? ◯Yes ◯No **(LTSS)**

Do friends or family members express concerns about Member's ability to care for themselves? ◯Yes ◯No

Coordination of Care Needs and Referrals:

HOUSING ENVIRONMENT

☐ **NoConcerns Noted**

Is Member able to safely and easily move around their home? ○ Yes ○ No **(LTSS)**

If No, does the place Member lives have: (Answer Yes or No to each individual item)

Good Lighting	○ Yes	○ No
Good Heating	○ Yes	○ No
Good Cooling	○ Yes	○ No
Rails for any Stairs or Ramps	○ Yes	○ No
Hot Water	○ Yes	○ No
Indoor Toilet	○ Yes	○ No
A door to the outside that locks	○ Yes	○ No
Elevator	○ Yes	○ No
Space to use a Wheelchair	○ Yes	○ No
Clear Ways to Exit Home	○ Yes	○ No
Stairs to get into your home or stairs inside your home	○ Yes	○ No

Coordination of Care Needs and Referrals:

FALL RISK

☐ **NoConcerns Noted**

Are you afraid of falling? ○ Yes ○ No **(LTSS)**

Have you fallen in the last month? ○ Yes ○ No **(LTSS)**

Coordination of Care Needs and Referrals:

MEDICAL EQUIPMENT

◯ **No Concerns Noted**

Diabetic machine/supplies	◯ Use	◯ Need
Urinary catheter/supplies	◯ Use	◯ Need
Tracheostomy/supplies	◯ Use	◯ Need
Suction machine/supplies	◯ Use	◯ Need
Walker	◯ Use	◯ Need
Wheelchair: ◯ Manual ◯ Electric or Scooter	◯ Use	◯ Need
Oxygen	◯ Use	◯ Need
Nebulizer	◯ Use	◯ Need
Tube feeding	◯ Use	◯ Need
Orthotic (e.g., foot, leg, or knee brace)	◯ Use	◯ Need
Hoyer Lift	◯ Use	◯ Need
Shower Chair/Transfer Bench	◯ Use	◯ Need
Hospital bed	◯ Use	◯ Need

Other:

Coordination of Care Needs and Referrals:

SOCIAL DETERMINANTS OF HEALTH

HOUSING

◯ **NoConcerns Noted**

Where does Member live?

- ◯ Live alone in their home/apartment
- ◯ Live with family or other person's home/apartment
- ◯ Residential Treatment Center
- ◯ Homeless (including shelter/vehicle)
- ◯ Skilled Nursing Care Pediatric Facility
- ◯ Protective housing
- ◯ Foster Care
- ◯ Other:

SOCIAL DETERMINANTS OF HEALTH (cont.)

If Homeless, staying at:

- ◯ In a motel
- ◯ Vehicle
- ◯ Shelter or with a friend
- ◯ Streets

Comment:

Is (Member/Family) risk for eviction? ◯ Yes ◯ No

If Yes, please explain:

Is anyone helping (Member/Family) with housing support (e.g. Housing Navigator, Case Management, Adult Protective Services)? ◯ Yes ◯ No

Is Member/Family on a housing waitlist? ◯ Yes ◯ No **If Yes:** ◯ County ◯ City ◯ Other

FINANCIAL INSECURITY

◯ **No Concerns Noted**

What is your monthly income? $

Source of Income: ◯ Employment ◯ SSI (Supplemental Security Income) ◯ SSDI (Social Security Disability Insurance)

Does (Member/Family) sometimes run out of money to pay for food, rent, bills and medications?

◯ Yes ◯ No **(LTSS)**

FOOD INSECURITY

◯ **No Concerns Noted**

In the last 12 months, has the (Member/Family) ever cut the size of their meals or skip meals because there was not enough money for food? ◯ Yes ◯ No

Has (Member/Family) experienced hunger or has not eaten because there is not enough food in the house?

◯ Often ◯ Not Often

SOCIAL DETERMINANTS OF HEALTH (cont.)

FOOD INSECURITY (cont.)

Coordination of Care Needs and Referrals:

ISOLATION

◯ **No Concerns Noted**

Over the past month (30 days), how many days has Member felt lonely? **(LTSS)**

Check one

◯ Member Never Feels Lonely

◯ Less than 5 days

◯ More than half the days (more than 15)

◯ Most days – Member Always Feels Lonely

SOCIAL SUPPORT (select all that apply)

◯ Family/Guardian/Foster Parent

◯ Child Care or Preschool Center

◯ Youth Education and Leadership Programs

◯ Tri-Counties Regional Center (TCRC)

◯ Peer-to-Peer Club

◯ Friends

◯ Church

◯ Team Sports

◯ School Counseling

◯ None

◯ Other:

Coordination of Care Needs and Referrals:

LEGAL INVOLVEMENT

- ◯ **No Member Concerns Noted**

Involvement with the following in the last 12 months:

- ◯ Court Ordered Services
- ◯ On Probation
- ◯ Deferred Action for Childhood Arrivals (DACA)
- ◯ On Parole
- ◯ Re-entry Program
- ◯ Immigration "e.g., Refugee"
- ◯ DUI/Restricted License
- ◯ Adult Protective Services
- ◯ Child Welfare Services
- ◯ Other:

Coordination of Care Needs and Referrals:

END-OF-LIFE-PLANNING

Does Member have life-planning document or advance directive in place?

- ◯ **Member** ◯ Yes ◯ No
- ◯ **Auth Rep** ◯ Yes ◯ No

Does Member or Guardian want information on these topics?

- ◯ **Member** ◯ Yes ◯ No
- ◯ **Auth Rep** ◯ Yes ◯ No

COMMUNITY AND LTSS SERVICES

Select Agencies or Services Member is connected with:

Involvement with the following in the last 12 months:

- ◯ * **Dual Eligible Special Needs Plan (D-SNP)**
- ◯ * **Hospice**
- ◯ * **Fully Integrated Special Needs Plans (FIDE - SNPs)**
- ◯ * **Program For All-Inclusive Care for the Elderly (PACE)**
- ◯ * **Multipurpose Senior Services Program (MSSP)**
- ◯ * **Self-Determination Program for Individuals with I/DD**
- ◯ * **Assisted Living Waiver (ALW)**
- ◯ * **California Community Transitions (CCT)**
- ◯ * **Home and Community-Based Alternatives (HCBA) Waiver**
- ◯ * **Medi-Cal Waiver Program (MCWP) (formerly HIV/AIDS Waiver)**
- ◯ Respite Services
- ◯ In-Home Supportive Services (IHSS)
- ◯ California Children's Services (CCS)
- ◯ Veterans Administration
- ◯ CalFresh Benefits
- ◯ WIC
- ◯ Food Bank
- ◯ Non-Medical Transportation
- ◯ Independent Living Resource Center
- ◯ Treatment or Counseling (for an emotional, developmental, or behavioral issues)
- ◯ Subsidized Housing
- ◯ County Specialty Mental Health
- ◯ Energy Assistance Program
- ◯ TCRC (Tri-Counties Regional Center)
- ◯ Free Government Phone
- ◯ Local Education Agency (LEA)/Special Education
- ◯ Palliative Care Services
- ◯ CalAIM Community Supports
- ◯ Other:

*** Members may be excluded from receiving ECM and these similar services at the same time.**

Coordination of Care Needs and Referrals:

PRIORITIES FOR MEMBER

What is one thing right now that can be done to improve your health (Member/AR)?

What would Member/AR like to achieve from our work and time together?

PRIORITIES FOR MEMBER (cont.)

From our meeting, today what comes to mind as the top 2-3 goals for Member health, mental wellness and social and/or living situation for the next 3-6 months?

1.

2.

3.

Tier 1: High Acuity, Recommended minimum one contact per week if any of the below apply

- ◯ Emergency Department (ED) visit or hospitalization (in the last 30 days)
- ◯ New diagnosis or new initiation of treatment (in last 30 days)
- ◯ Documented or known non-adherence (medication, treatment, or appointments)
- ◯ Little or no identified social support
- ◯ Homeless or recently secured permanent housing (within the last 90 days)

Tier 2: Moderate Acuity, Recommended minimum (3x/month) contact if any of the below apply

- ◯ ED visit or hospitalization within the last 2-6 months
- ◯ Newly sustained treatment adherence (medications, appointments)
- ◯ Newly integrated social support
- ◯ Secured permanent housing within last 3-6 months
- ◯ At risk of homelessness

Tier 3: Low Acuity, Recommended minimum one contact per month if any of the below apply

- ◯ No ED visit or hospitalization (in the last 6 months)
- ◯ Ongoing treatment adherence (medications, appointments)
- ◯ Strong family/social support
- ◯ Stable housing

NARRATIVE SUMMARY

Include Primary Needs identified from Assessment:

Assessor's Printed Name: _____ Signature/Credentials _____ Date _____