ENCOMPASS FAMILY HEALTH HOME

Children Initial Needs/Eligibility Assessment

Enrollment Date: _____ Date of scheduled Initial Interdisciplinary Team Meeting: _____

Child's Name: _____

First Name MI Last Name

Address: _____

Street Apt No

_____

City State Zip Code +4

Phone: ( ) - ( ) - Email: _____

Home Cell

Gender: ☐ M ☐ F

☐ Medicaid # _____

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Ethnicity: ☐ Asian ☐ Black/African American ☐ Native American ☐ White/Caucasian
☐ Pacific ☐ Hispanic/Latin American ☐ Native Alaskan ☐ Other _____

Referral Source: Name: _____ Phone Number: ( ) -

Parent/Guardian/Caregiver:

( ) -

Name Phone Number Relationship

_____

Street Apt No City State Zip Code + 4

Consenter (If different from above): Name: _____ Phone Number: ( ) -

Address: _____

Current Service Providers/ Supports (*Contact Person, Address and Phone Number*):

Family Support	☐ Yes	☐ No	_____
School(s)	☐ Yes	☐ No	_____
Physician(s)	☐ Yes	☐ No	_____
Psychiatrist	☐ Yes	☐ No	_____
Therapist	☐ Yes	☐ No	_____
Substance Tx	☐ Yes	☐ No	_____
Hospital Preference	☐ Yes	☐ No	_____ Hospital Name and Address
CPS/DSS Worker	☐ Yes	☐ No	_____
Foster Care	☐ Yes	☐ No	( ) - Telephone No

Other Contact:

_____ ( ) -

Name Address

_____ ( ) -

Name Address

_____ ( ) -

Name Address

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Health Conditions: check appropriate boxes:

☐ AIDS/HIV (**Attach supporting documentation from Medical or Social Work Provider indicating HIV Status, date of diagnosis, most recent viral load count and most recent CD4 count.);* ***AND/OR***

☐ SED: Serious Emotional Disturbance

List all conditions: _____

_____

AND/OR

☐ Complex Trauma (**Attach all supporting documentation and assessments);*

OR

☐ 2 or more Chronic Conditions:

1. _____
2. _____
3. _____
4. _____

Current Medications		
Name	**Dose**	**Frequency**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Alerts/ Safety Concerns:

☐ Needle Disposal Issues
☐ Domestic Violence
☐ Homelessness
☐ Suicide Attempts/Threats
☐ Self-Injurious Behaviors
☐ History of Assault
☐ Frequent Crisis Requiring Readmission
☐ Victim of Physical/Sexual Abuse
☐ Allergies
☐ Medication Adherence
☐ Other _____

Other Co-Occurring Conditions:

☐ Serious Medical Issues
☐ Smoker; packs per day (Choose from drop down) 0
☐ Developmental Disability
☐ Seizure Disorder
☐ Visual Impairment
☐ Hearing Impairment
☐ Impaired Ability to Walk
☐ Wheelchair Required
☐ Substance Use
☐ Other _____
☐ Other _____

Health Home Eligibility Verification:

Active Medicaid ☐ Yes ☐ No

Qualifying Diagnosis Confirmed ☐ Yes ☐ No

Source: _____
(*Attach all supporting documentation)

Appropriateness Criteria:

☐ At probable risk for adverse events (e.g.: death, disability, inpatient or nursing home admission, mandated preventive services or out of home placement);
☐ Has inadequate social/family/housing supports or serious disruptions in family relationships;
☐ Has inadequate connectivity with healthcare system;
☐ Does not adhere to treatments or has difficulty managing medications;
☐ Has been recently released from incarceration, placement, detention or psychiatric hospitalization;
☐ Has deficits in activities of daily living skills, learning or cognition issues; or
☐ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.

Child/Family Immediate Needs:

Immediate Interventions:

_____ _____ _____ _____
Child Signature Date Parent/Guardian Signature Date

_____ _____
Care Manager Date

_____ _____
Supervisor Date

Completed Forms:

HH Consents: ☐ Yes ☐ No RHIO Consent: ☐ Yes ☐ No PSYCKES Consent : ☐ Yes ☐ No CANS-NY Consent: ☐ Yes ☐ No