Molina

Enhanced Care Management Provider Manual

CCA Users

April 28, 2023

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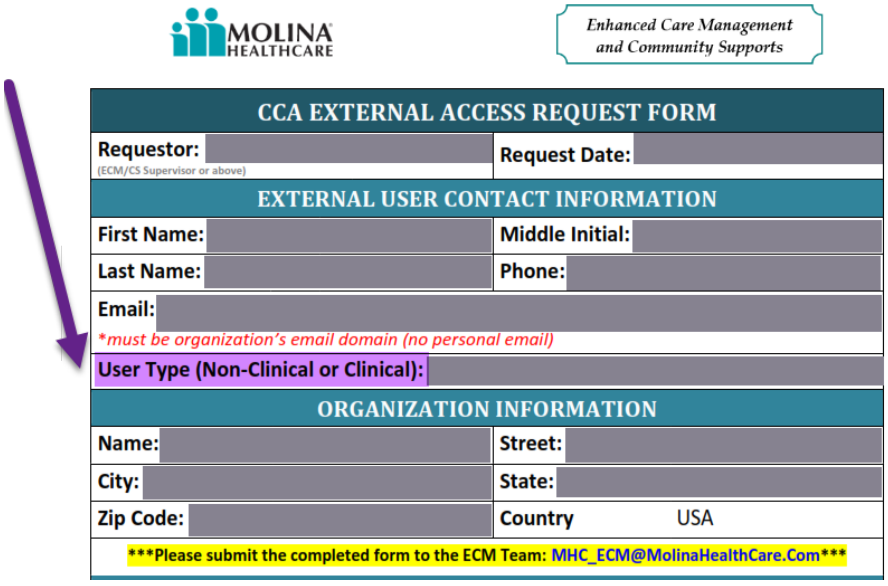
Clinical Care Advance

ECM Providers are required to document all member activities in Molina's Clinical Care Advance (CCA) case management platform. CCA documentation is considered the source of truth for all ECM-related member activities and is subject to regulatory/internal audits. When requesting access to CCA, a supervisor or above must complete the *ECM-CS CCA External Access Request Form* and submit it to Molina's ECM Team: MHC_ECM@MolinaHealthCare.Com . The ECM-CS CCA External Access Request Form must be completed in its entirety and accurately, especially the User Type section (Non-Clinical or Clinical), as this impacts our encounters submissions. We want to ensure we are correctly reporting encounters made by non-clinical staff versus clinical staff.



MOLINA HEALTHCARE

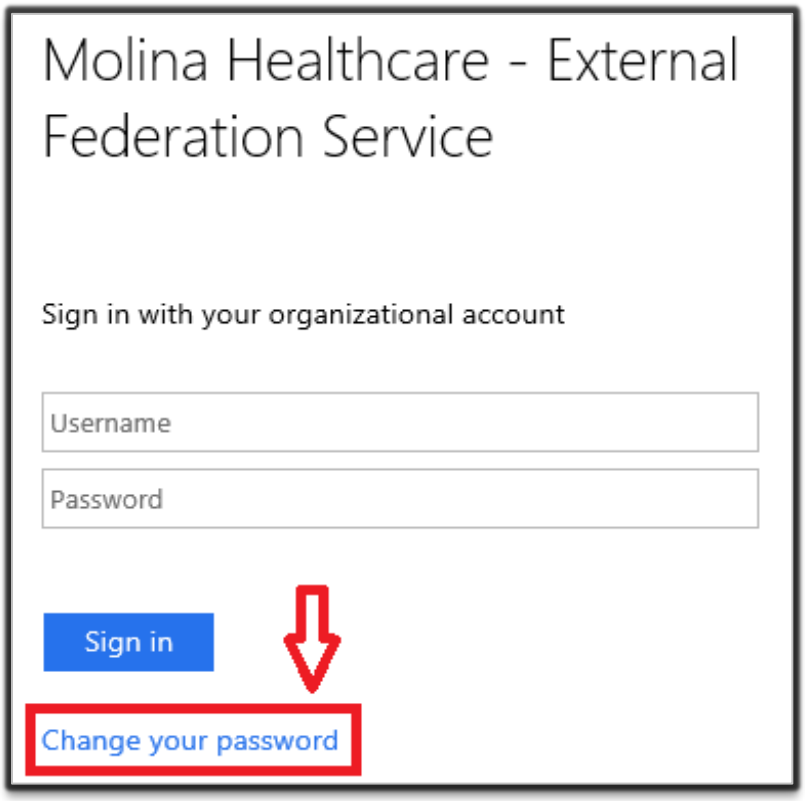
Enhanced Care Management and Community Supports

CCA EXTERNAL ACCESS REQUEST FORM	
Requestor: (ECM/CS Supervisor or above)	**Request Date:**
EXTERNAL USER CONTACT INFORMATION	
First Name:	**Middle Initial:**
Last Name:	**Phone:**
Email: *must be organization's email domain (no personal email)*	
User Type (Non-Clinical or Clinical):	
ORGANIZATION INFORMATION	
Name:	**Street:**
City:	**State:**
Zip Code:	**Country** USA
Please submit the completed form to the ECM Team: MHC_ECM@MolinaHealthCare.Com	

In the event that someone from your organization leaves or no longer needs access to CCA, your organization will need to inform Molina's ECM Team immediately to disable the user's access.

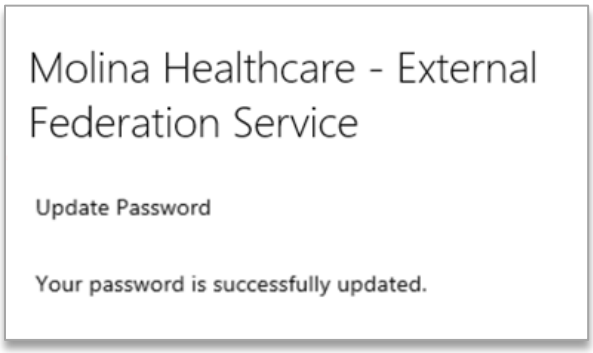
Logging into CCA

1. Pre-requisites
    a. **Supported Browser(s)**: Clinical Care Advance **only** works in Microsoft Edge
2. Please ensure that your Edge settings are updated, as they expire every 30 days. Copy and paste the link below into the Microsoft Edge browser address bar to log into the Care Clinical Advance Production Environment. https://careadvance.molinahealthcare.com/
3. If you are a first-time user, you must change your password before Logging in to Clinical Care Advance. Please Click on **Change your Password** to change your password.



4. Please type in username prefixed with Molina\username and password received in your email. Type your new password in New password and Confirm the new password. Click on **Submit** to update your Password.

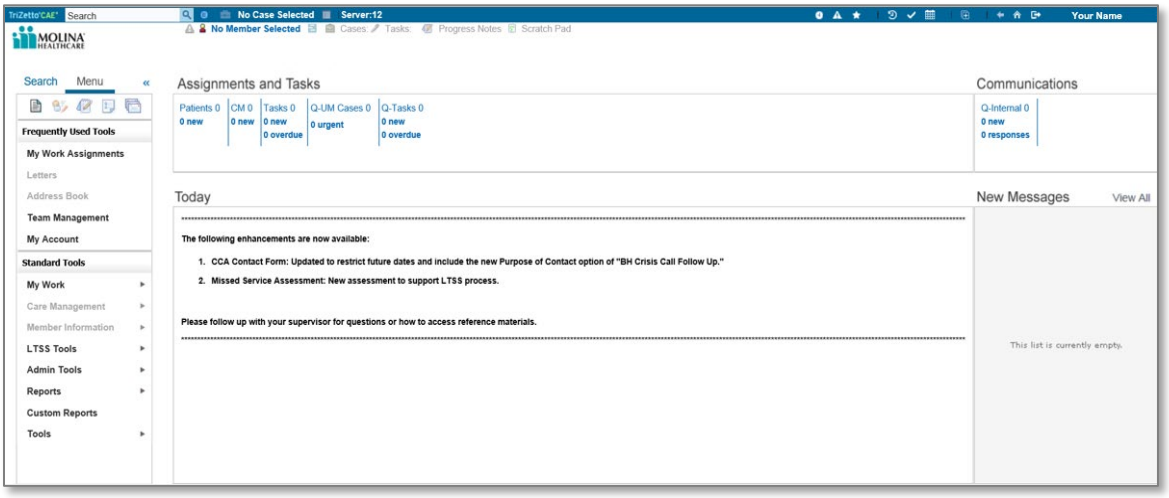
Note: Your username is not your email. In most cases, it will be the first four letters of your last name followed by the first four letters of your first name.



5. Copy and paste the link below into the Microsoft Edge browser address bar to return to the Login for the Care Clinical Advance Production Environment. https://careadvance.molinahealthcare.com/

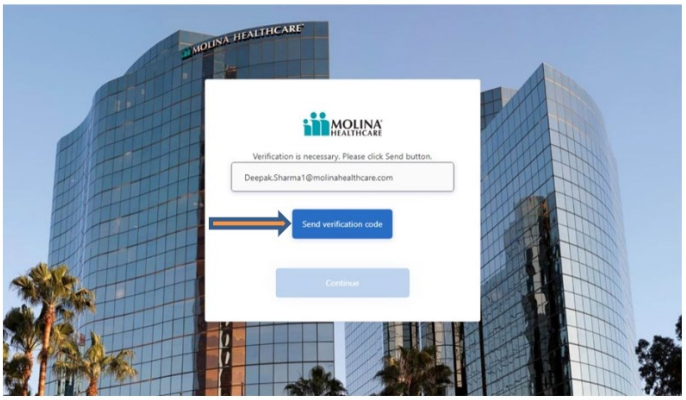
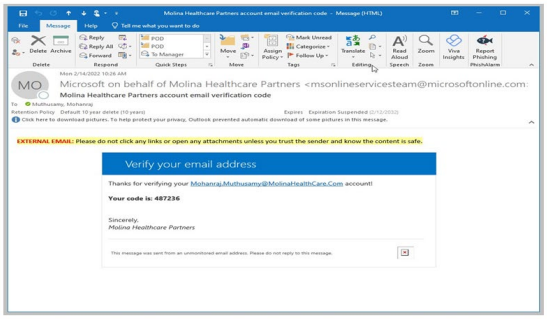
6. Please Type in your username ***without the prefix Molina***, then type in your new password. Click **Sign in** to Log in.

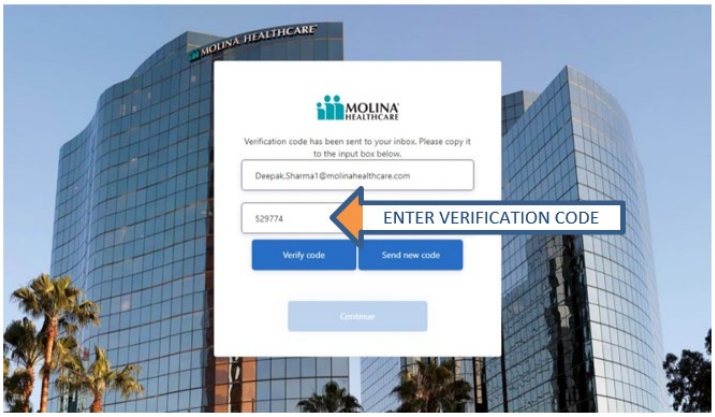
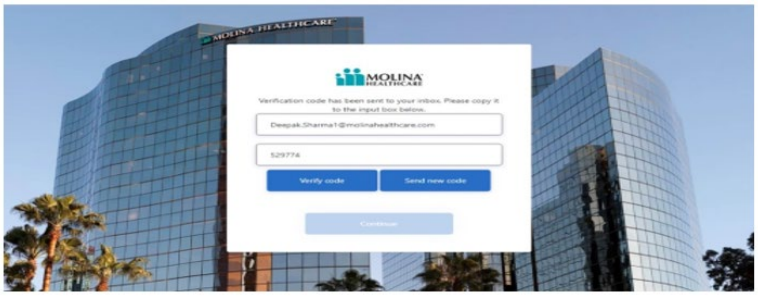
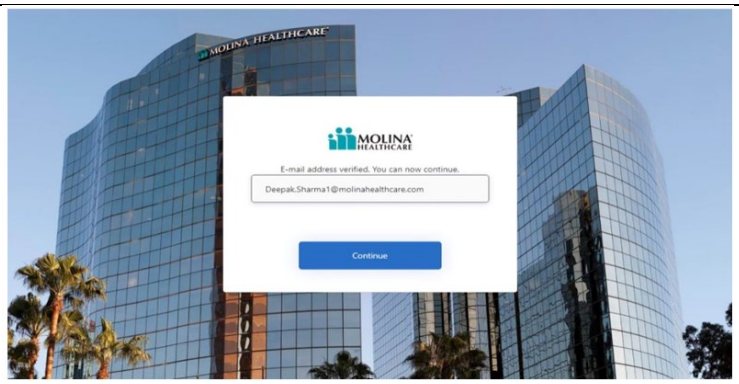
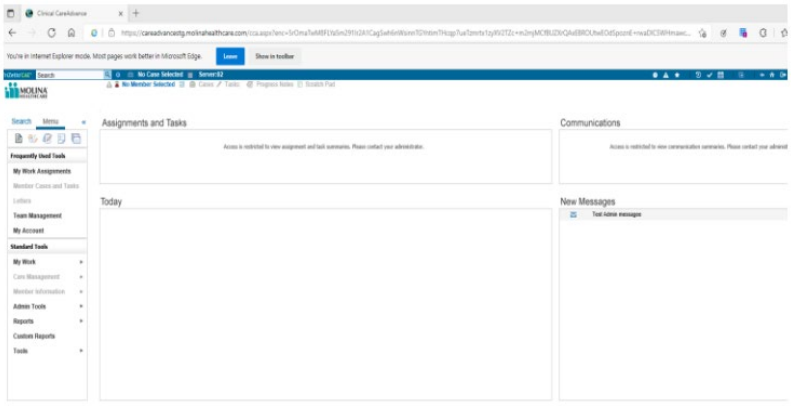
7. You are now in the CCA Production Environment. This is where all our live members live. Any completed action or process is all done here in the production environment.



8. After you have already Logged in to the production environment, use this link to access the Test Environment https://careadvancetraining.molinahealthcare.com/. Doing this will automatically take you to the CCA Test Environment. You can practice the scenarios provided by Molina and enter data on test patients here.

CCA 2FA Steps

INSTRUCTION	SCREESHOT
Step 1: Open Microsoft Edge . Copy the link below to the browser URL to access CCA **https://careadvance.molinahealthcare.com**	
Step 2: The user is redirected to the Molina Login screen (SSO)	
Step 2: Enter Molina user credentials ▪ Username: Enter Username (please refer to new user credentials email) ▪ Password: Enter Password (******) ▪ Click on the sign-in button	
Step 3: The user will be promoted to send 2FA code to the user's registered work email:	
Step 4: After clicking on send verification code button, 2FA code will be sent to the user's work email in 1-2 minutes (will be valid for 5 minutes)	*If user does not receive email within 2 mins, check junk mail. If email is not received, reach out to internal IT team to ensure email is not blocked.* 

INSTRUCTION	SCREESHOT
Step 5: Enter 2FA code received from the email	
Step 6: Click on Verify code	
Step 7: A success message is shown after the email is verified. Click **Continue** to log into CCA	
Step 8: Successful login to Clinical CareaAdvance (CCA) application	

Enabling Internet Explorer integration on Microsoft Edge using Group Policy

Complete the following steps to enable Internet Explorer integration on Microsoft Edge using Group Policy.

1. Download the policy file from Microsoft Edge Policy Template.
2. Extract the downloaded Policy File folder MicrosoftEdgePolicyTemplates.
3. Copy msedge.admx, msedgeupdate.admx , and msedgewebview2.admx file from C:\Users\{user}\Downloads\MicrosoftEdgePolicyTemplates\windows\admx to C:\Windows\PolicyDefinitions.
4. Copy msedge.adml, msedgeupdate.adml , and msedgewebview2.adml file from C:\Users\{user}\Downloads\MicrosoftEdgePolicyTemplates\windows\admx\en-US to C:\Windows\PolicyDefinitions\en-US.
5. Open Group Policy Editor.
6. Click **User Configuration/Computer Configuration** > **Administrative Templates** > **Microsoft Edge**.
7. Double-click **Configure Internet Explorer integration**.
8. Select **Enabled**.
9. Under **Options**, set the drop-down value to **Internet Explorer mode** if you want the sites to open in IE mode on Microsoft Edge.

Configuring the Enterprise Mode Site List policy

Configure IE mode with a separate policy for Microsoft Edge. This additional policy allows you to override the IE site list. For example, some organizations target the production site list to all users. Using this policy, you can then deploy the pilot site list to a small group of users.

1. Create or reuse a Site List XML (C:\temp\sites.xml) (This can be set to desired location)

   All sites with the element *<open-in>IE11</open-in>* will now open in IE mode.

Example:

```
<site-list version="205">
<!-- Begin Site List -->
<site url="CCA URL">
<compat-mode>IE8Enterprise</compat-mode>
<open-in>IE11</open-in>
</site>
</site-list>
```

2. Open Group Policy Editor.
3. Click **User Configuration/Computer Configuration** > **Administrative Templates** > **Microsoft Edge**.
4. Double-click **Configure the Enterprise Mode Site List**.
5. Select **Enabled**.
6. Under **Options**, type the location of the website list. You can use one of the following locations:

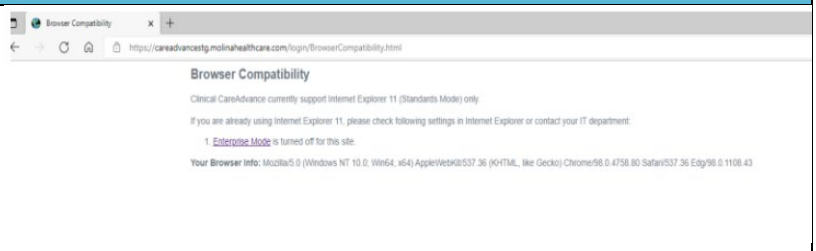
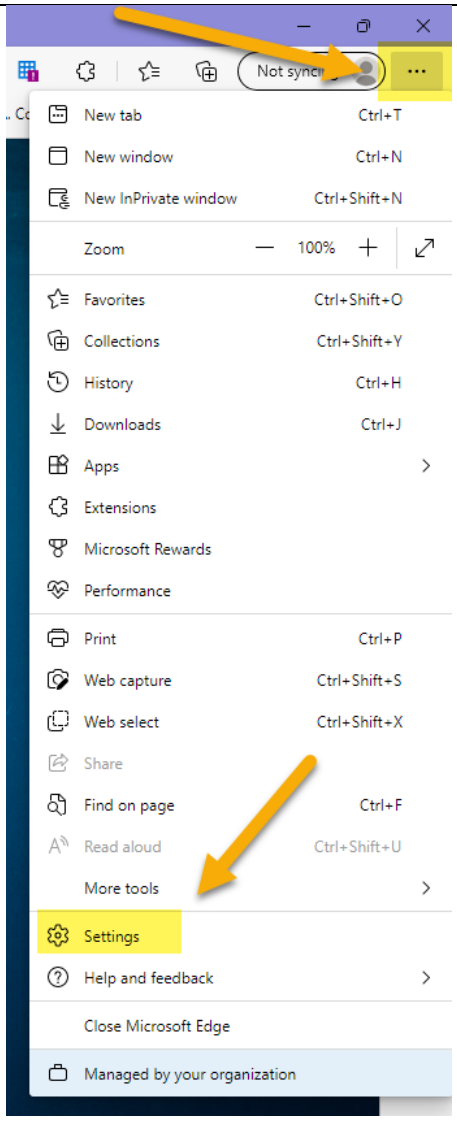
   CCA Prod: https://careadvance.molinahealthcare.com

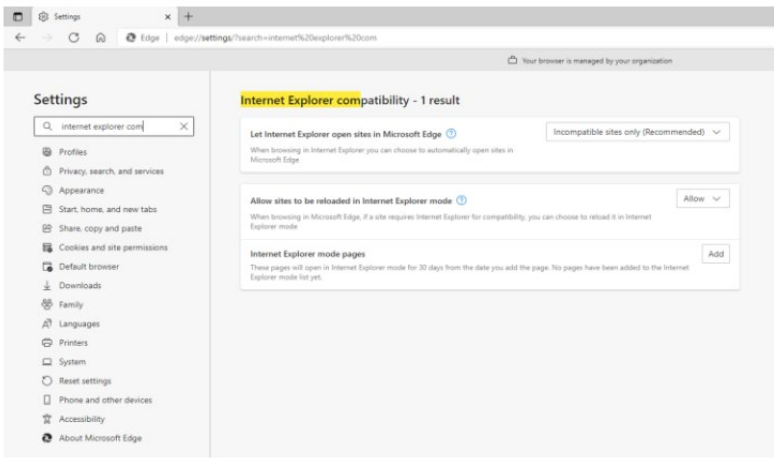
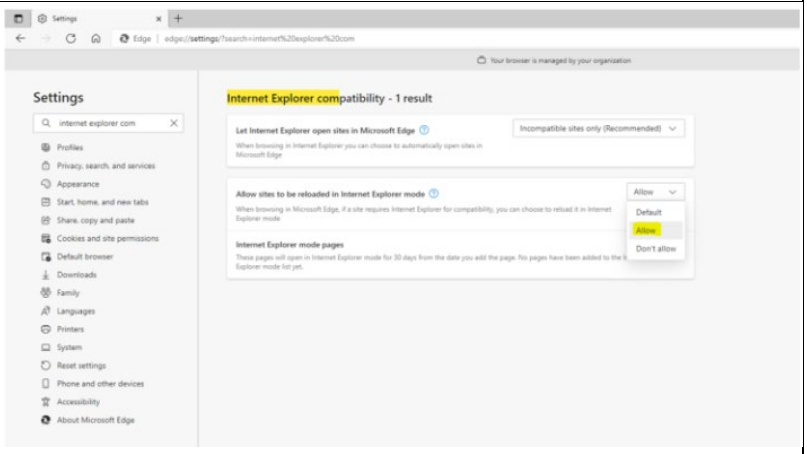
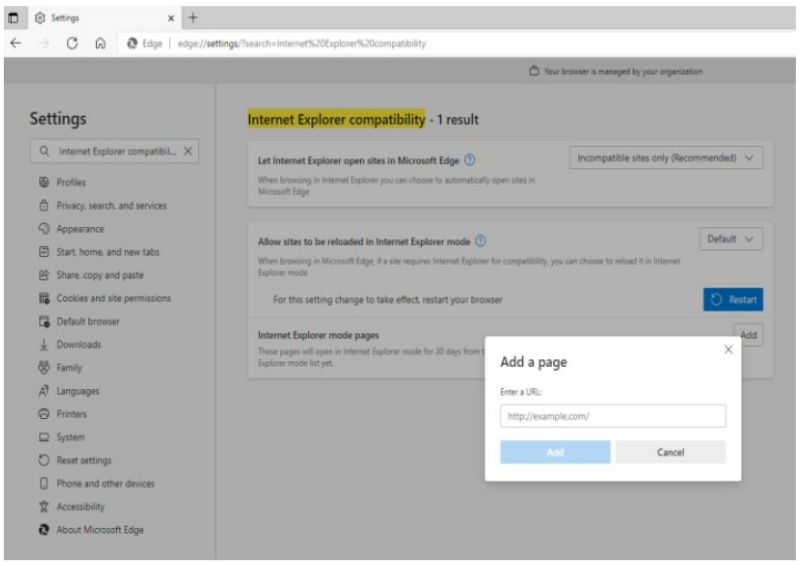
   CCA Training: https://careadvancetraining.molinahealthcare.com

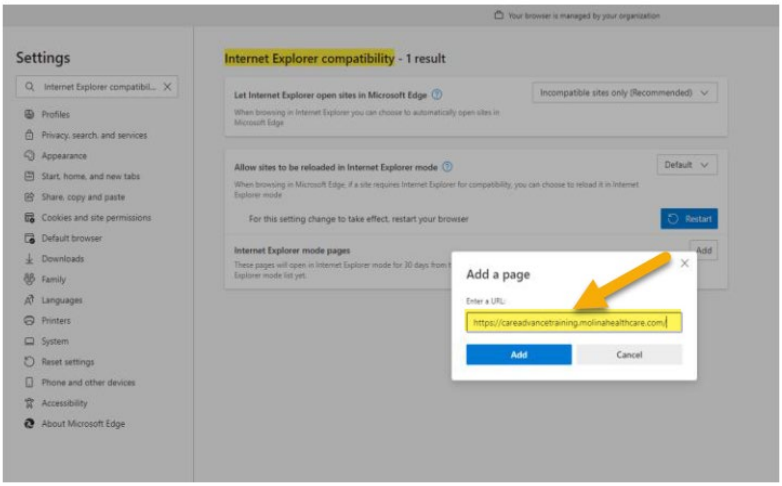
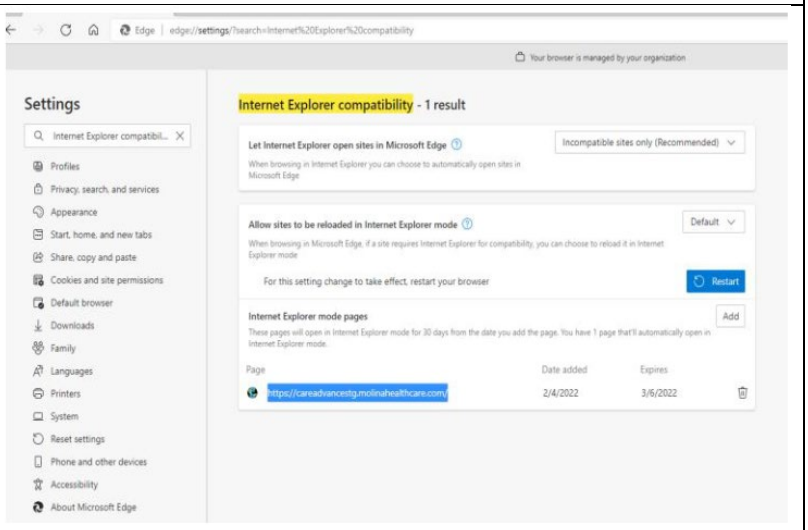
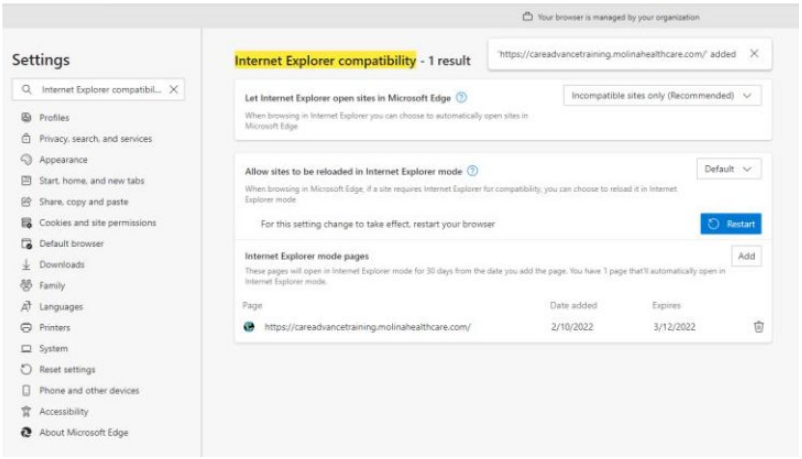
   Local file: file:///c:/Temp/sites.xml(This should be same as defined on step 1)

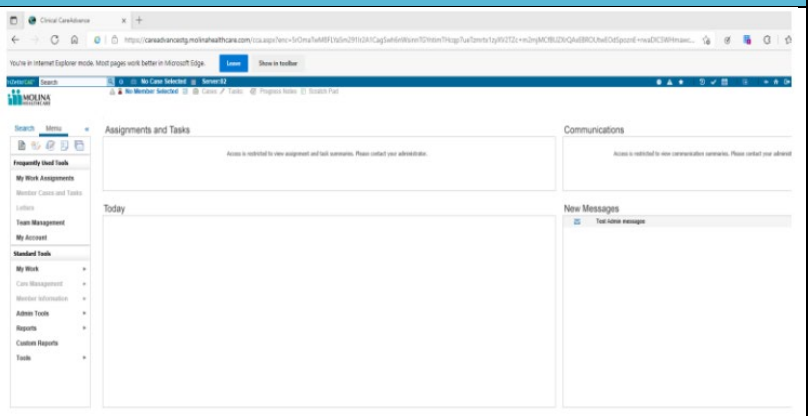
7. Click **OK** or **Apply** to save these settings
8. Restart Microsoft Edge and browse CCA URLs set in the sites.xml.
9. You should be able to see the CCA site open in IE mode. To verify this, check the internet explorer icon near the URL bar.

Microsoft Edge Setup for Clinical Care Advance

INSTRUCTION	SCREENSHOT
You might encounter this screen when you open the Clinical Care Advance link in Microsoft Edge Browser. Use the instructions below to open Clinical Care Advance application on Microsoft Edge.	
Step 1: Open the Microsoft Edge browser, click on the three dots in the top right corner, and select Setting options.	

INSTRUCTION	SCREENSHOT
Step 2: Open the Settings pages and search for “Internet Explorer Compatibility”	
Step 3: Select the dropdown “Allow sites to be reloaded in Internet Explorer mode” values and change it to “Allow”	
Step 4: Click Add on “Internet Explorer mode pages,” and “Add a page” will be prompt	

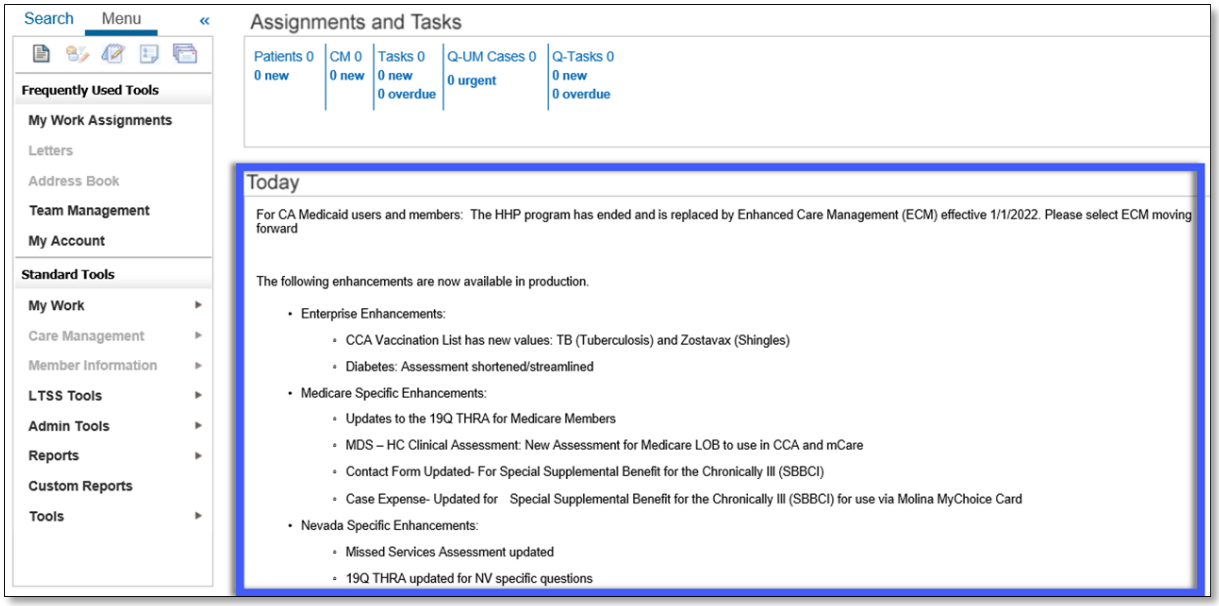
INSTRUCTION	SCREENSHOT
Step 5: Type Clinical Care Advance URL and click on Add For CCA Prod **https://careadvance.molinahealthcare.com** For CCA Training **https://careadvancetraining.molinahealthcare.com/**	
Step 6: Ensure the added URL appears on the page sections	
Step 7: Click restart, and the Microsoft Edge page will be closed.	

INSTRUCTION	SCREENSHOT
Step 8: Now launch the CCA application on Microsoft Edge, and the CCA application will launch successfully	

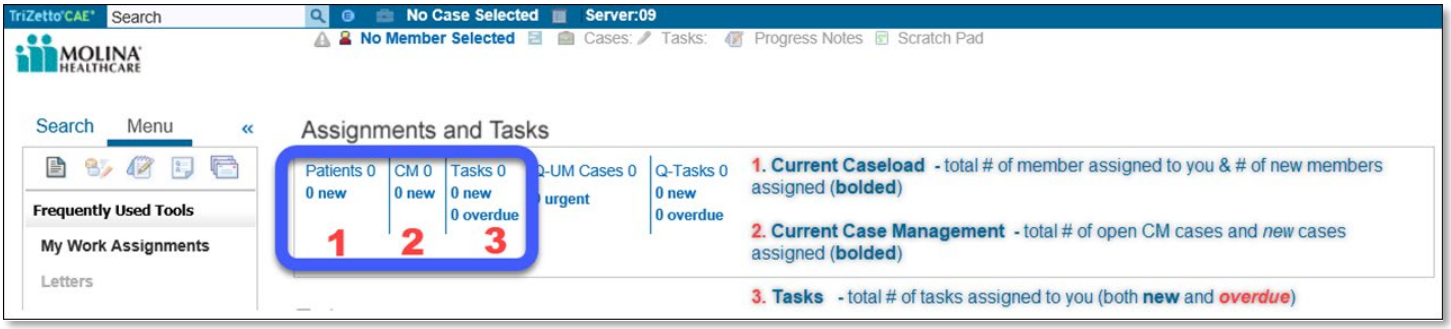
Basic Navigation of CCA

Today's Section in CCA

The Today section of the CCA home page displays company-wide announcements or messages regarding any new CCA system activities (i.e., campaigns, reports, new features, updates, etc.).



Assignments & Tasks



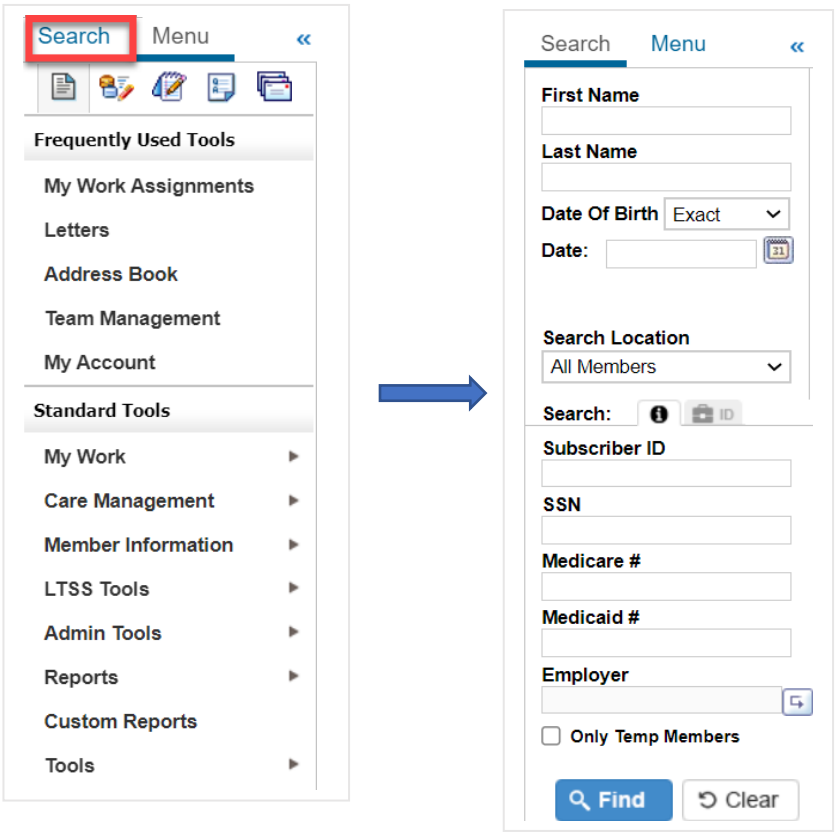
Patients: Displays users' Current Caseload à, total # of members (patients) assigned to users & # of new members assigned (**bolded**)

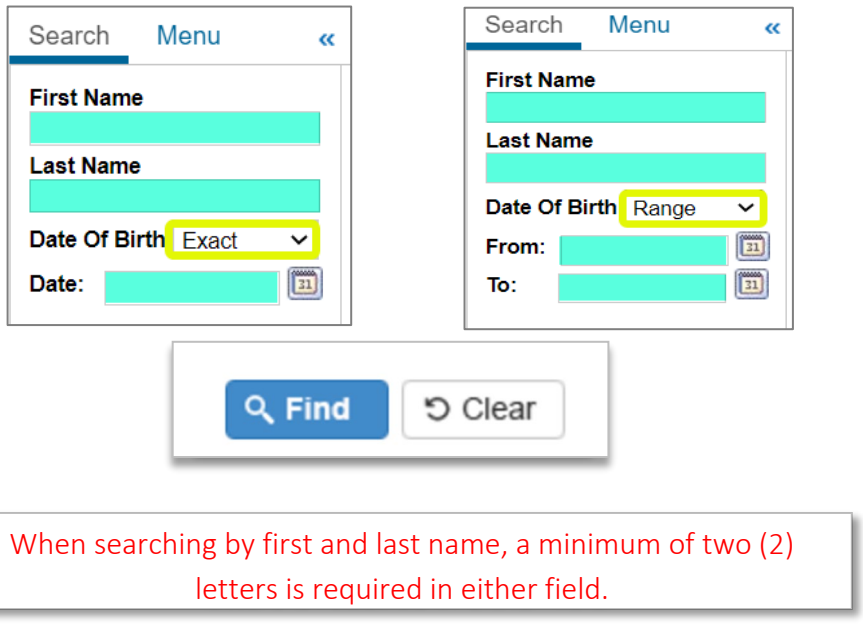
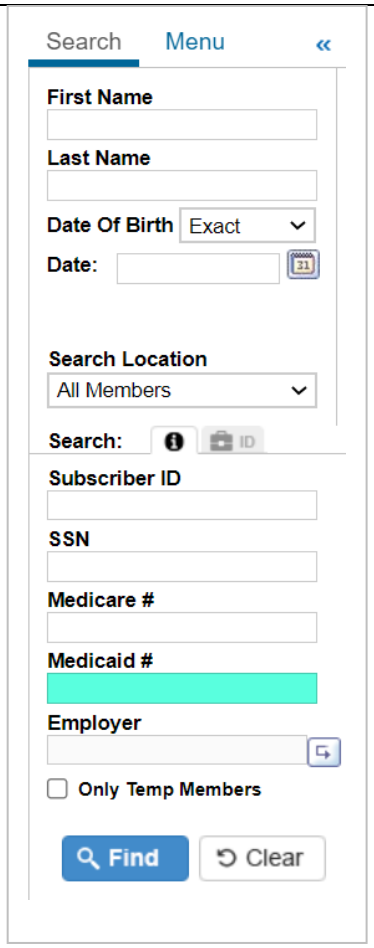
CM: Allows the user to view their Current Case Management à # of opened CM cases and new CM cases assigned (**bolded**)

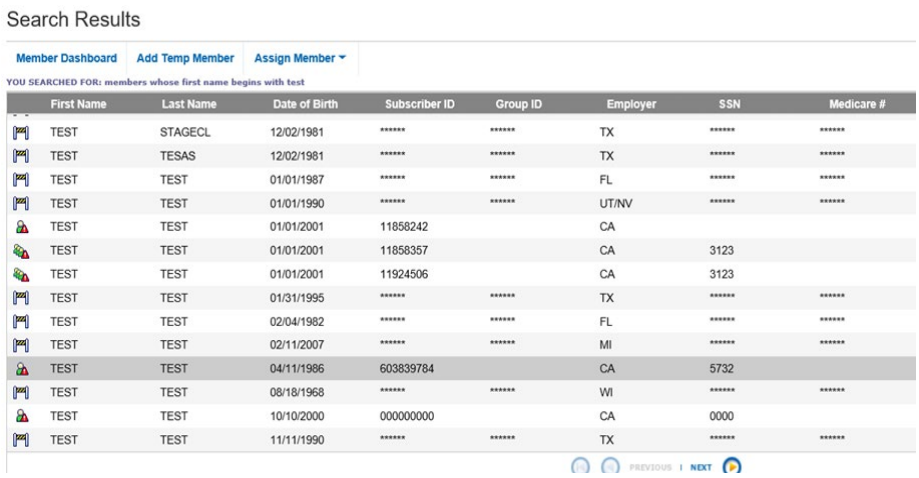
Tasks: Shows # of tasks assigned to the user (both **new** and *overdue*); last two columns not used (not applicable to ECM).

Searching for and Selecting Members in CCA

Many CCA functions work directly with a member's record, so you must find and select the member to "**bring them into focus**." In the Search tab, you go to put in the information you have for the member. This allows users to search for members not currently assigned to them.

INSTRUCTIONS	SCREENSHOT
Step 1: Select **Search** from the Vertical Menu Bar to bring up the search menu.	

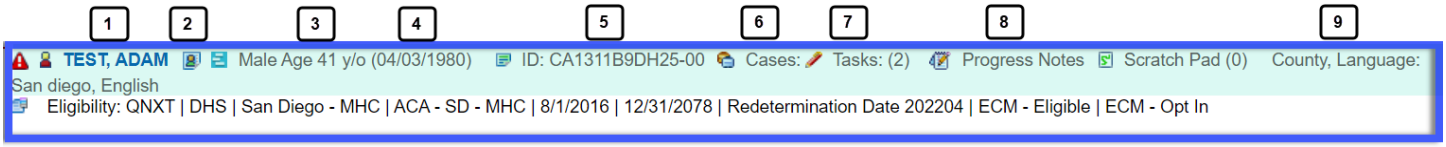
INSTRUCTIONS	SCREENSHOT
Step 2: There are two (2) ways to search for members: **Option #1 –** The first way is to enter the member's first name, last name, and date of birth. Select the **Exact** Date of Birth from the dropdown if you have the member's birthdate. Select **Find**. or Select **Range** from the dropdown if you do not have the Date of Birth, but you have an approximate age range; enter those dates and select **Find**.	 When searching by first and last name, a minimum of two (2) letters is required in either field.
Cont. Step 2: **Option #2 –** The second way to search for a member is to enter their **Medicaid ID**, also referred to as the member's **CIN**. Select **Find**.	

INSTRUCTIONS	SCREENSHOT
Step 3: Once the list of members populates, click the **member's name** to bring the member "IN FOCUS." **Note: If a member is restricted, you cannot access the member's CCA profile. Members might be restricted because they are no longer with our plan or might have a hold restriction. If this is the case, please check Availity. Other reasons might be that the member was disenrolled from the ECM Program or missing a condition code to allow the ECM Provider to access the member. Reach out to Molina's ECM Team Inbox immediately if this occurs. Molina's ECM Team will troubleshoot the issue.**	

Member Banner

When a member is '**in focus**,' the member's name appears at the top of the screen in the Member Banner. The Member Banner displays two lines of important information about the member.

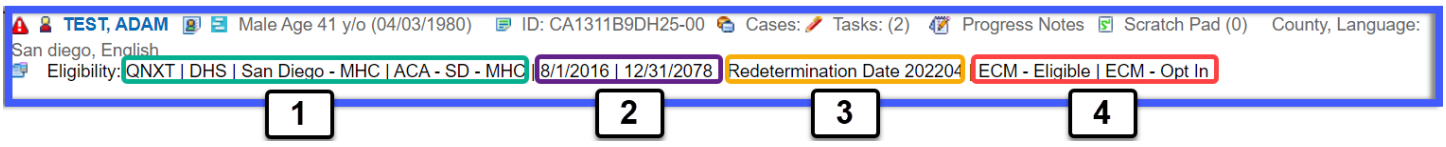
Top Line: Displays general information about the member in focus.



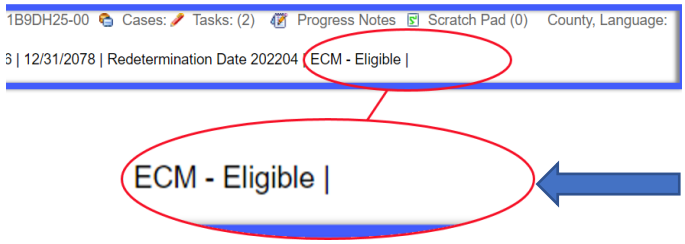
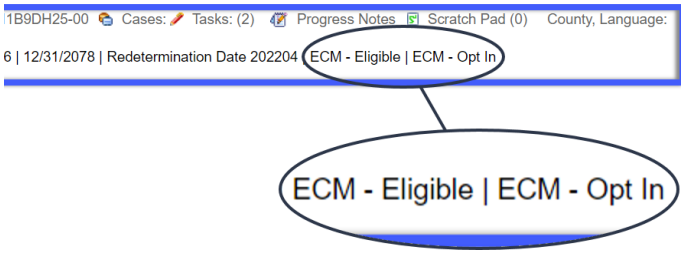
Member's name

1. Member's Dashboard icon
2. Gender, Age
3. DOB
4. Molina ID#
5. Member's cases (*you can click here to view the member's case history*)
6. Tasks associated with the member (*you can click here to view all tasks associated with the member*)
7. Progress notes
8. Primary language

Bottom Line: Includes the member's Eligibility Information. You want to always look at the member banner when bringing a member into focus to see if the member is **eligible** for ECM and whether the member is **enrolled** (or **Opted In**).



1. **Line of Business** (LOB) or **Product Description.** Please note member eligibility is ever-changing. If you see a member with counties San Bernardino or Riverside **and** have an "HN," please inform Molina's ECM Team immediately. If you see a member with county Los Angeles and Health Net under the Eligibility, don't be alarmed, these are member's Health Net delegates to Molina.
2. **Enrollment** & **Termination** date with Molina (*12/31/2078 is the default if there is no active termination date*).
3. **The redetermination Date** is when the member's Medicaid eligibility must be renewed with the state.
4. **ECM Program Information – ECM Eligibility | ECM Enrollment Status**. Here is where you can find information on whether a member is eligible for ECM and if the member is or is not enrolled in ECM.

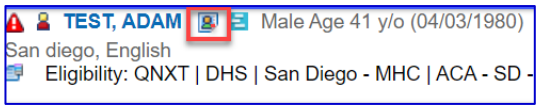
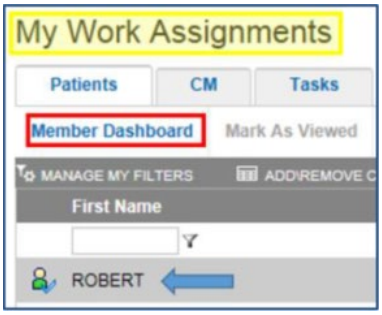
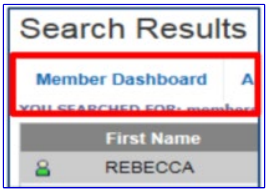
Member is NOT Enrolled in ECM (NOT Opted In)	Member is Enrolled in ECM (Opted In)
	

Member Dashboard

The Member Dashboard contains a summary of member data and quick access to detailed information for a specific topic. Molina is sunsetting the Custom Report-Member 360 Report soon. ECM Providers should be reviewing the Member Dashboard as part of their pre-call review exercise (more information on this is below). In addition, if an ECM Provider cannot reach a member due to insufficient contact information, they should review the Member Dashboard for additional member contact information.

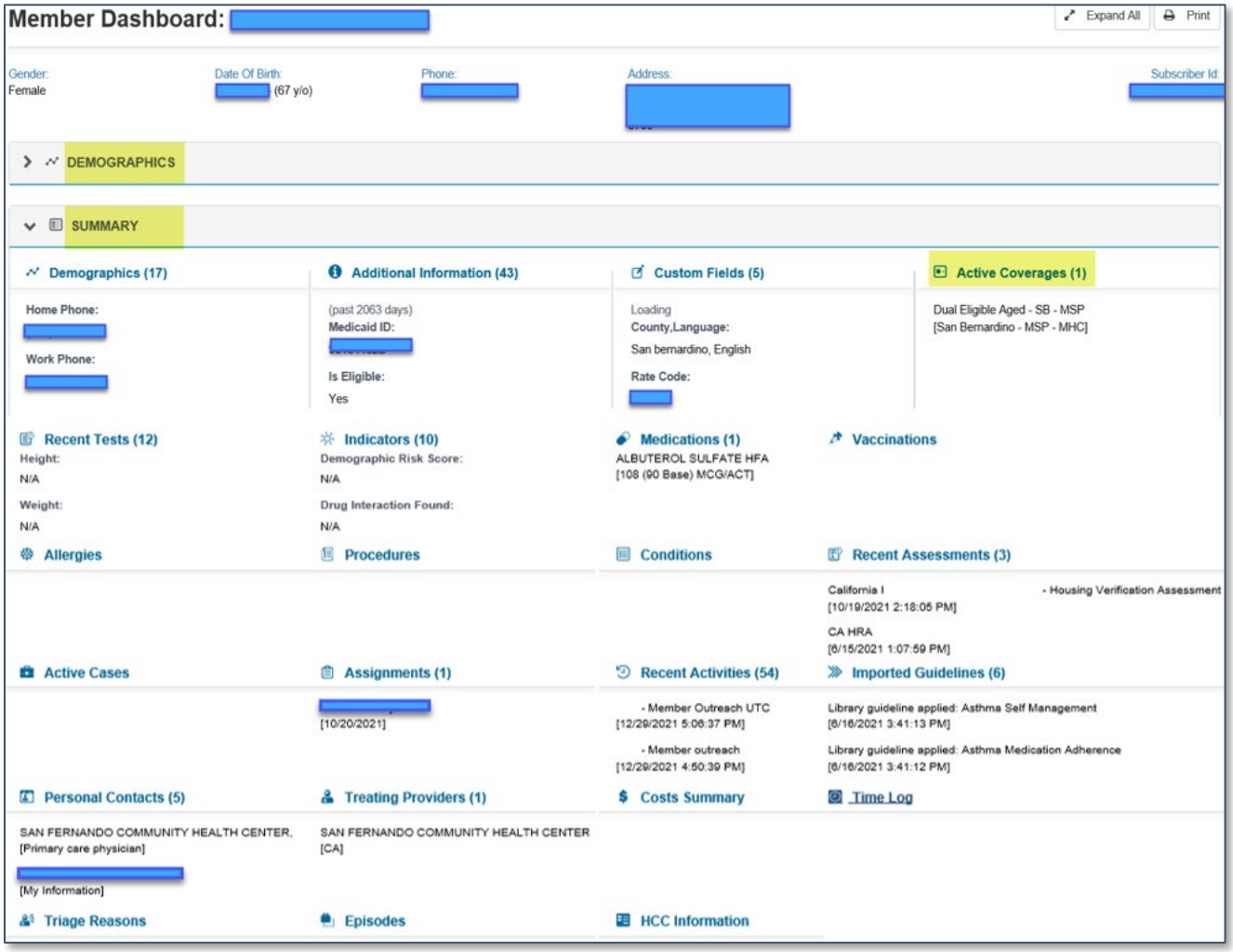
To access the Member Dashboard:

INSTRUCTIONS	SCREENSHOT
Step 1: Bring a member **in focus**.	

INSTRUCTIONS	SCREENSHOT
Step 2: There are four (4) ways to access **Member Dashboard**. i. The **icon** by member's name (displays Member Dashboard in a separate pop-up window) *Recommended* ii. Member Dashboard tab under "My Work Assignments" (changes the main screen to Member Dashboard) iii. **Member Information à Member Dashboard** (changes the *main screen* to Member Dashboard) iv. **Search Results à** *When searching for a member, this section lets users view the dashboard once the member is selected.*	***Recommended*** i.  ii.  iii.  iv. 

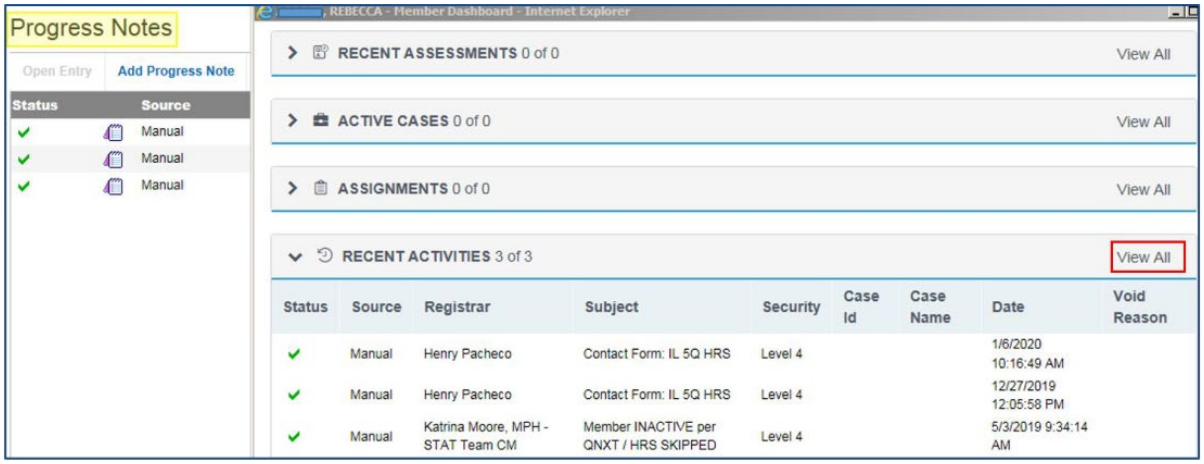
The Member Dashboard is organized into sections. ***Header, Demographics,*** and ***Summary*** are located at the top of the page to provide quick views of member information.

Example of the Demographics and Summary Sections of the Member Dashboard



Note: The Member Dashboard information is ***VIEW ONLY.***

- When viewing a category in the Member Dashboard (e.g., Recent Activities), you can only view a maximum of five (5) entries. To view *all* entries, click on **View All.**



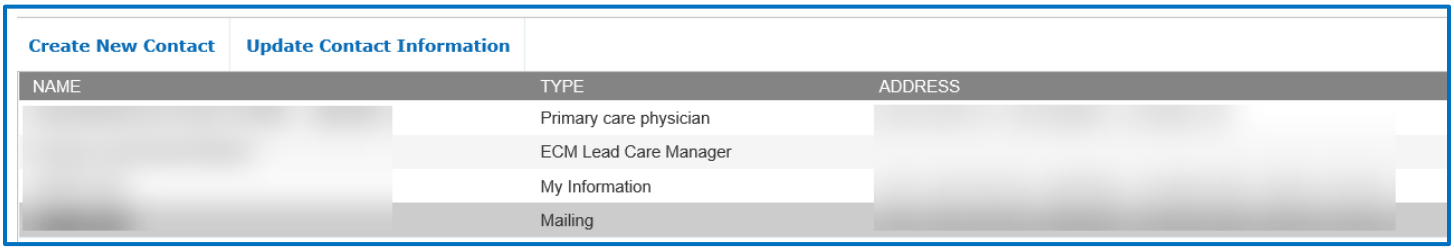
Note: If you click on **View All**, the *main* screen in the background or on another monitor will change to show that section you wish to view to allow you to view all entries.

Member Dashboard Sections		
Active Cases	HCC Information	Member Claim – Details
Active Coverages	Imported Guidelines	Personal Contacts
Additional Information	Indicators	Procedures
Allergies	Medications	Recent Activities
Assignments	Member Care Data - Alert Summary	Recent Assessments
Conditions	Member Care Data - Authorization	Recent Tests
Costs Summary	Member Care Data - Behavioral Summary	Summary
Custom Fields	Member Care Data - ED Summary	Time Log
Demographics	Member Care Data - Inpatient Summary	Treating Provider
Eligibility-Additional Attributes	Member Care Data - Office Visit Summary	Triage Reasons
Eligibility-Relationship	Member Care Data - Other Claims Summary	Utilization Active Authorization
Eligibility-Restriction	Member Care Data- Communication Summary	Utilization Inactive Authorization
Episodes	Member Care Data- Immunization Summary	Vaccinations

Address Book

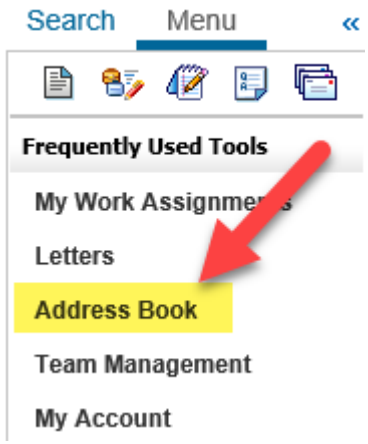
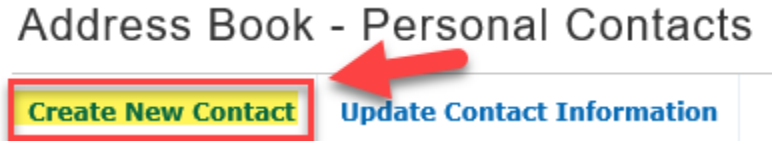
ECM Providers can find their assigned member's contact information (referred to as *My Information* in CCA), as well as the member's mailing information and the member's Primary Care Physician contact information (if a member has secondary insurance with Molina, this information might not be available in CCA). Suppose a member needs to update their contact information and/or PCP information. In that case, the ECM LCM needs to assist the member with changing this information by calling Molina's Member Services.

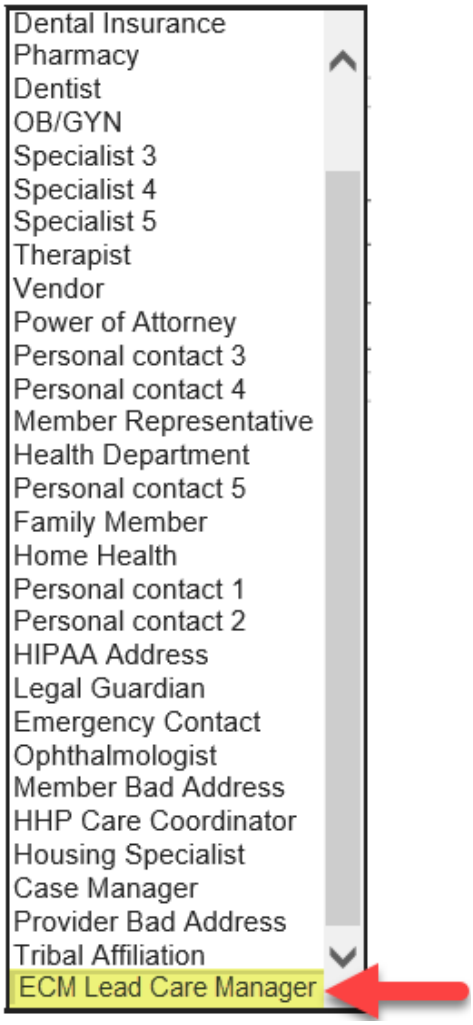
Address Book in CCA

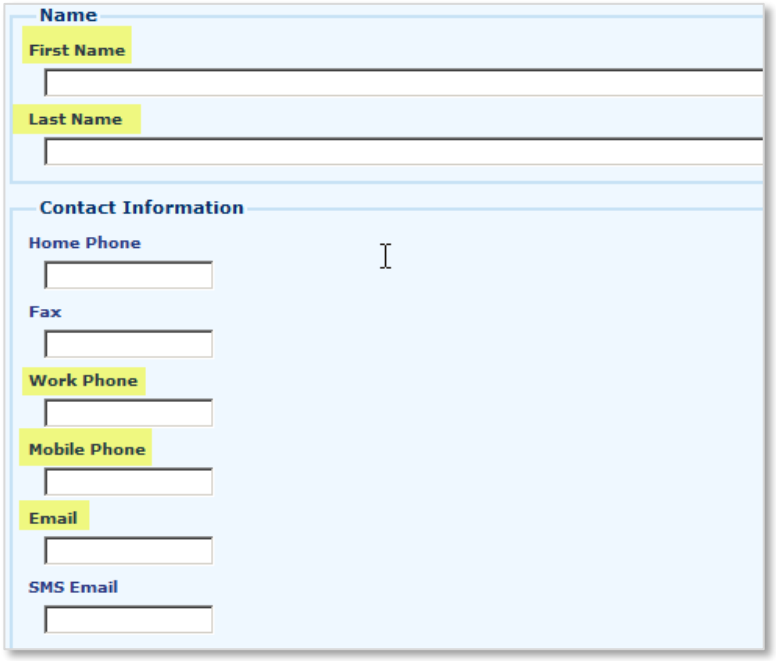


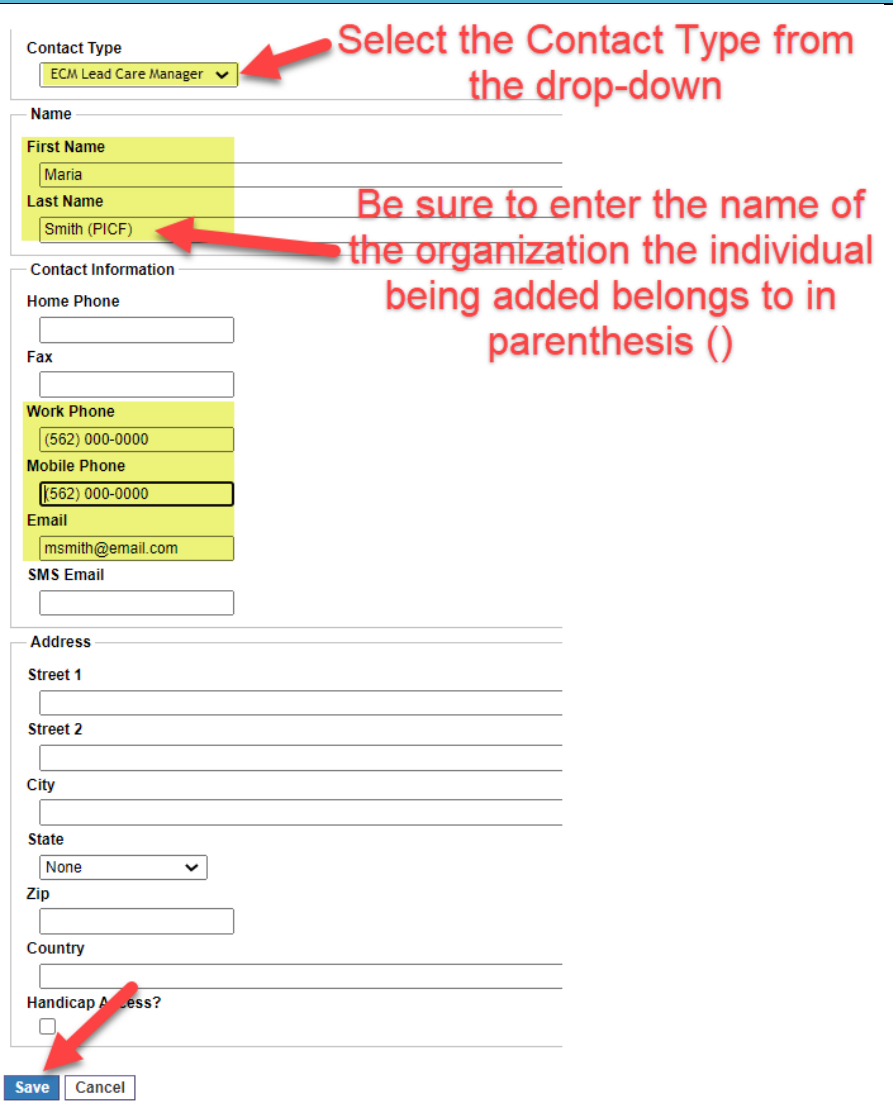
The assigned ECM LCM must enter their contact information within five business days of enrolling the member in the Address Book. We encourage the ECM LCM to enter any pertinent contact information in the Address Book, such as ICT members.

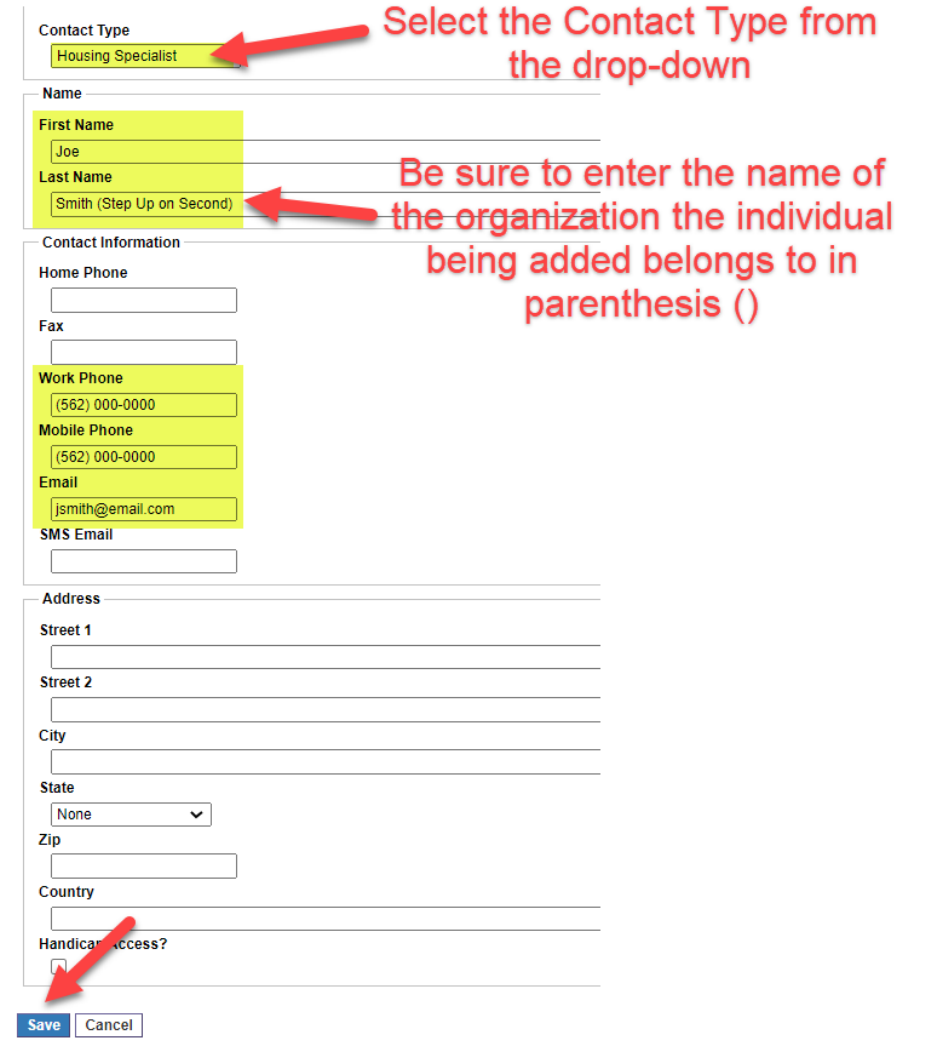
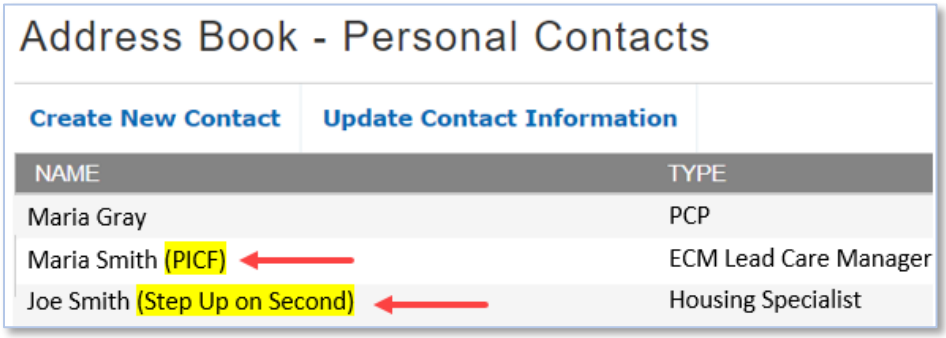
Follow the steps below to add the ECM LCMs contact information to the Address Book:

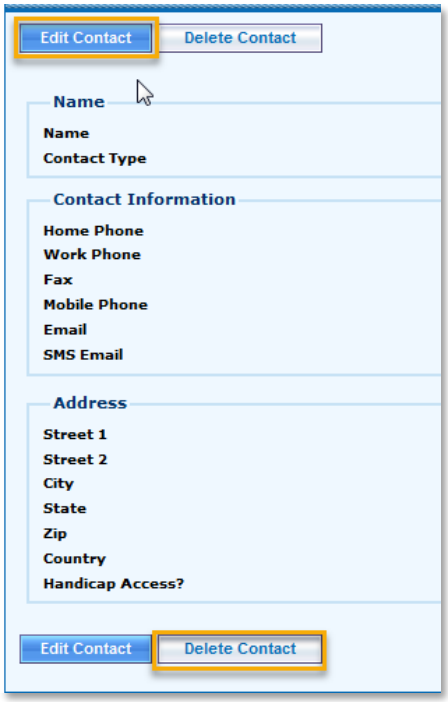
INSTRUCTIONS	SCREENSHOT
Step 1: Access Module There are multiple ways to access Address Book; the shortcut is displayed. Click on **Address Book**	
Step 2: Click on **Create New Contact**	

INSTRUCTIONS	SCREENSHOT
Step 3: Choose Contact Type from the drop-down list: Select **ECM Lead Care Manager** • For member contacts, select **Personal Contact.** • For PCP and specialists, select **Specialist.** • Select **Other** for the other options that are not listed.	**Contact Type** 

INSTRUCTIONS	SCREENSHOT
Cont. Step 3: Fill out the rest of the form as appropriate IMPORTANT: In the last name field, place the name of the organization the individual being added belongs to in parenthesis. Example: Smith (PICF) To finish, click **Save**.	

INSTRUCTIONS	SCREENSHOT
	

INSTRUCTIONS	SCREENSHOT
Once completed, the new contact(s) will be displayed in the **Address Book – Personal Contacts** window.	 

INSTRUCTIONS	SCREENSHOT
Please note: Only manually entered contacts in the Address Book can be **edited** or **deleted**.	

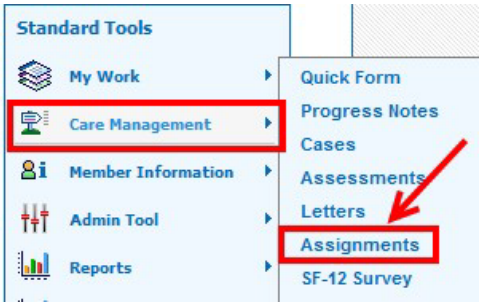
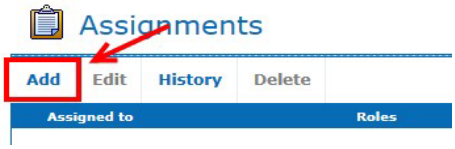
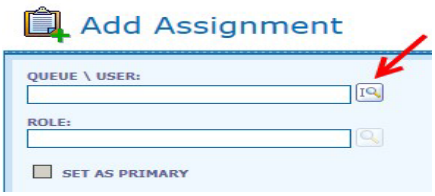
Assigning an ECM Lead Care Manager to an Enrolled Member

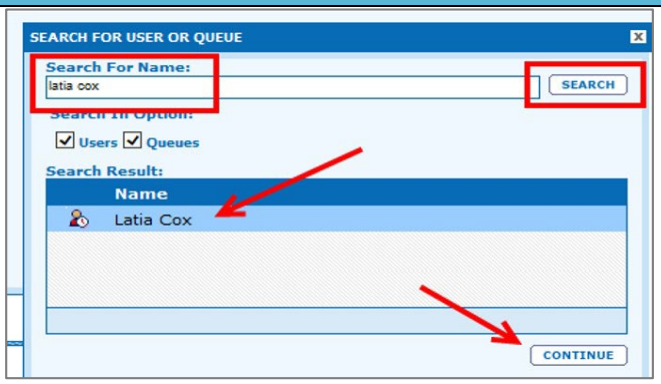
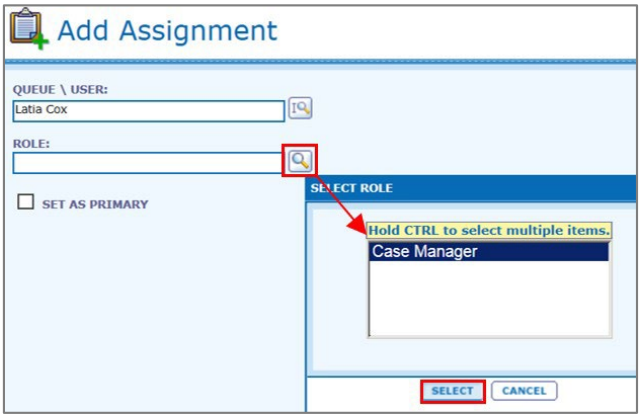
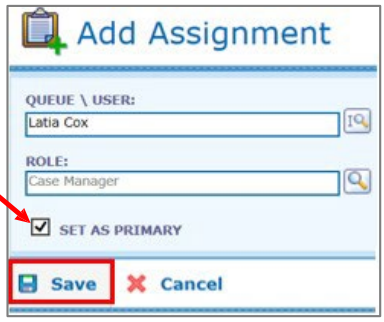
As mentioned above, once a member has been enrolled into ECM, the ECM Provider must assign an ECM Lead Care Manager (LCM) within 5 business days from the enrollment date. If the assigned ECM LCM leaves the organization, the ECM Provider must immediately reassign the member to another ECM LCM. ECM Providers must enter the ECM LCM's contact information in the Address book in CCA and assign the ECM LCM as the Primary CM under the Assignments in CCA; the ECM LCM entered in both sections needs to match. If your organization reassigns any of our members to a different ECM LCM in the future, those updates need to be reflected in CCA immediately.

Before disenrolling a member, the ECM LCM needs to remove their contact information from the Address Book and remove themselves from the Assignments in CCA.

Adding and Removing Assignments in CCA

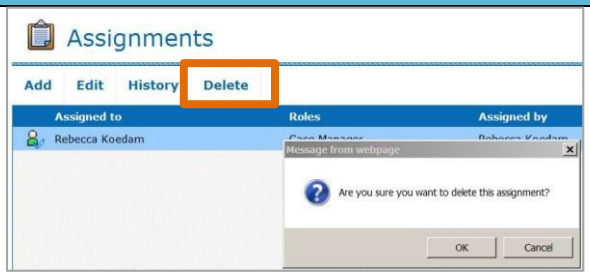
Follow the steps below to assign a member to your caseload or another ECM staff:

INSTRUCTIONS	SCREENSHOT
Step 1: Once the member is selected and in focus, go to the **Care Management** tab under Standard Tools to assign the member to a CM staff or yourself. a. Click Care Management b. Click Assignments	
Step 2: Click **ADD**.	
Step 3: Under **QUEUE\USER**, click on the magnifying glass.	

INSTRUCTIONS	SCREENSHOT
Step 4: Enter the staff name and select **SEARCH**. Search results will populate staff names. Select the appropriate staff name and then click **CONTINUE**.	
Step 5: Under **ROLE**, click the magnifying glass and select the appropriate role. If the staff is the primary case manager, check the box **SET AS PRIMARY**; otherwise, leave the box empty. **The ECM LCM is required to select SET AS PRIMARY.** Click **Save**	 

Deleting Assignments in CCA

Follow the steps below to delete yourself or someone else from the member's Assignment in CCA. ECM LCMs are required to do this before disenrolling a member & when reassigning a new ECM LCM to a member:

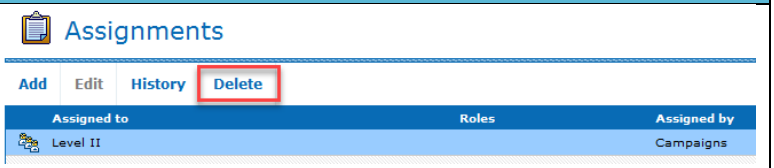
INSTRUCTIONS	SCREENSHOT
You can remove a member from your caseload by contacting Case Management – Assignments. Select your name and click [**DELETE**] -> [**OK**].	 ***NOTE: Cannot remove assignment if there is an open case.**

Deleting Campaigns in CCA

Molina uses "campaigns" to ensure members receive the correct level of care. Campaign assignment is based upon responses to the CA HRA. For example: Based on the data within the HRA, the member could be assigned to categories Maternity – CA HRA, Level 1 – CA HRA, Level 2 – CA HRA, or Level 3 – CA HRA.

The campaign will generate the following business day of HRA completion; the ECM LCM is required to task themselves to remove the campaign post-HRA completion. If the campaign is not removed post-HRA completion, the member could be redirected to another Molina business unit.

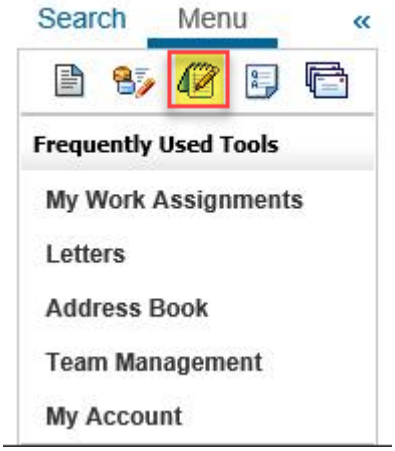
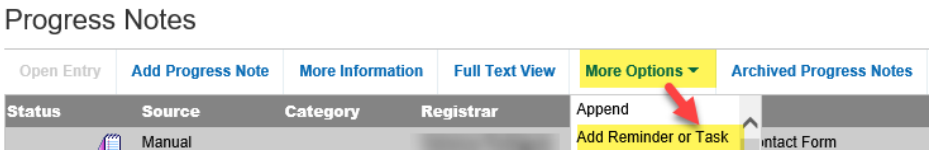
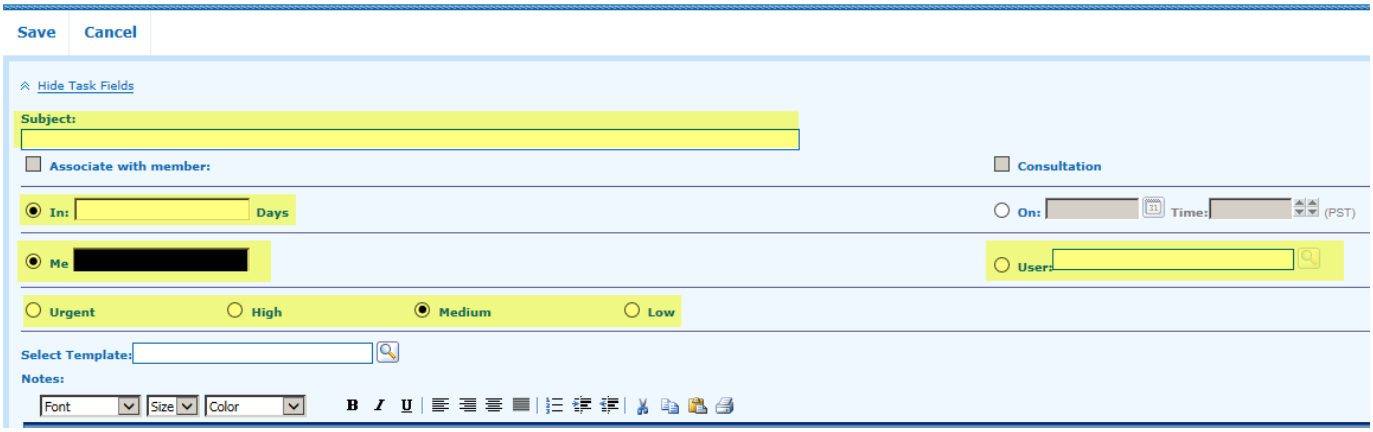
Follow the steps below to delete a campaign under Assignments:

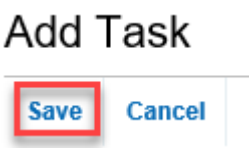
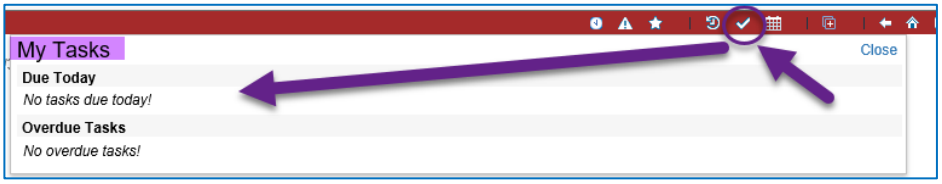
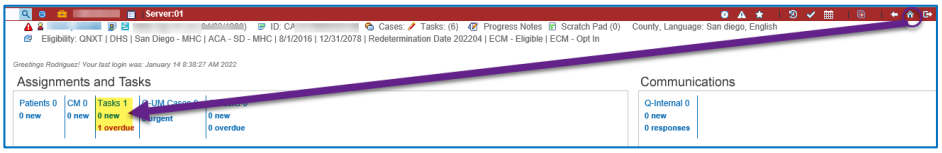
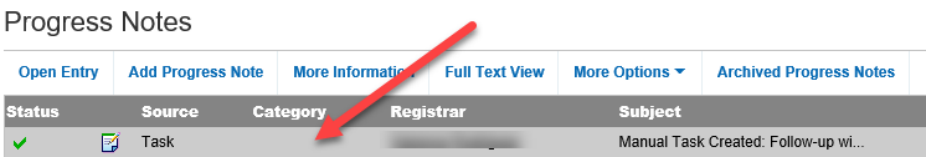
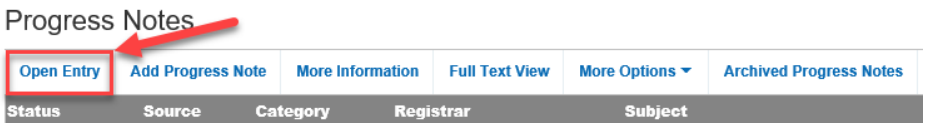
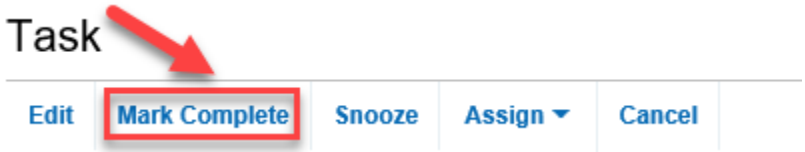
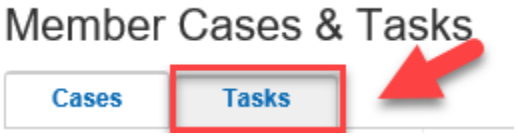
INSTRUCTIONS	SCREENSHOT
ECM LCM is required to delete campaigns from the Assignments in CCA. You can delete these campaigns by going to Case Management – Assignments. If you see the following campaigns under the Assignments, please delete them: **Maternity, Level I, Level II, or Level III.** Select ***campaign*** (Level II in this example) Click [**DELETE**] -> [**OK**].	

Task Function

Tasks are reminders for the external user to complete or follow up on certain action items (i.e., UTC follow-up attempts, assessments to be completed, follow-up calls to members/providers, sending correspondence or educational materials, scheduling case conferences, ECM care plan updates, as applicable housing voucher renewal application, etc.). ECM Providers documenting in CCA are required to use the task function for all action items, including but limited to the CA-HRA Reassessment and if the member requested the Advance Directives booklet in another language as discussed during the completion of the CA-HRA. Before disenrolling a member, the ECM LCM is required to close all pending tasks.

Below are the steps for creating a task and how to view tasks in CCA:

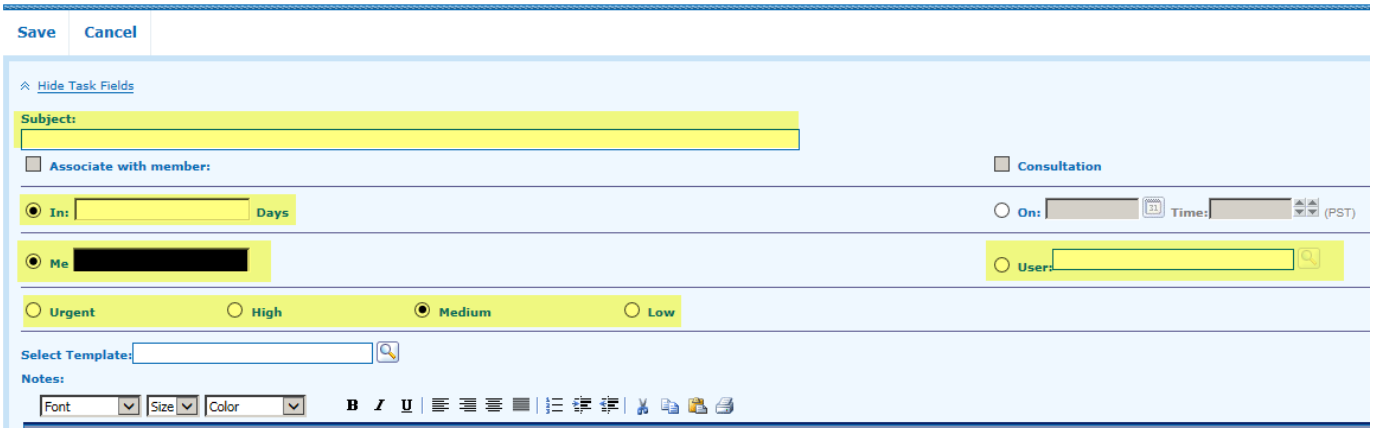
INSTRUCTIONS	SCREENSHOT
Step 1: There are multiple ways to create Tasks These steps are for creating Tasks from the *Progress Notes module.* Click on the notepad icon.	
Step 2: Bring an entry into focus (gray-out) & click on Add Reminder or Task	
Step 3: Fill out highlighted items as appropriate A task can be assigned to yourself, "Me," or another "User" in CCA.	

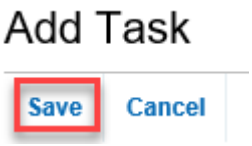
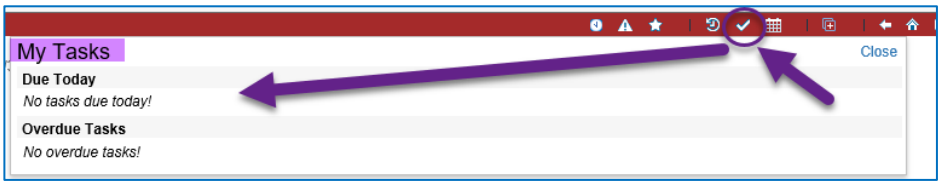
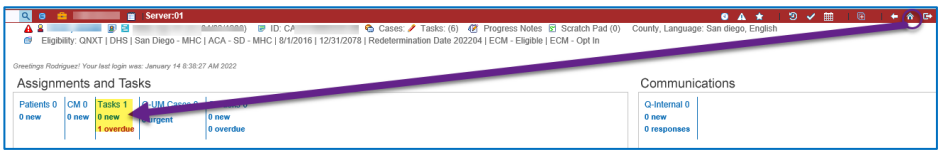
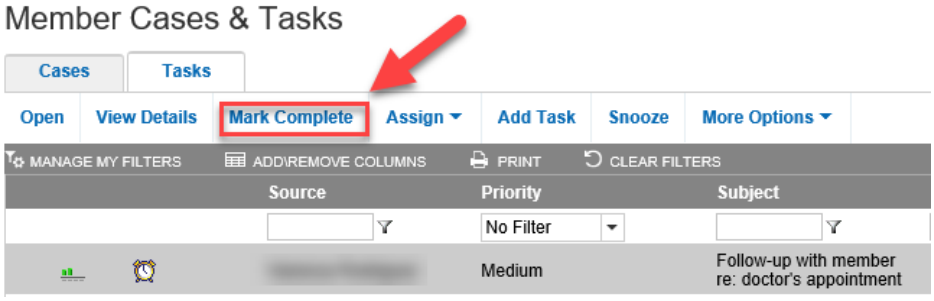
INSTRUCTIONS	SCREENSHOT
Step 4: Select **Save**	
Step 5: To check your **Tasks,** click on the check mark at the top-right-hand corner or the Home icon at the top-right-hand corner.	 
Step 6: When the Task has been completed, the user can click on the **Task, Open Entry,** and choose **Mark Complete**	  
Step 1: These steps are for creating Tasks from the *Member Cases & Task module* Click on the briefcase icon and then select the Tasks tab	 

INSTRUCTIONS	SCREENSHOT
Step 2: Select **Add Task**	

Step 3: Fill out highlighted items as appropriate

A task can be assigned to yourself, "Me," or another "User" in CCA.

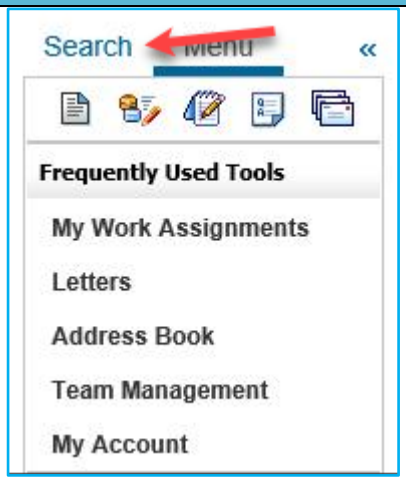
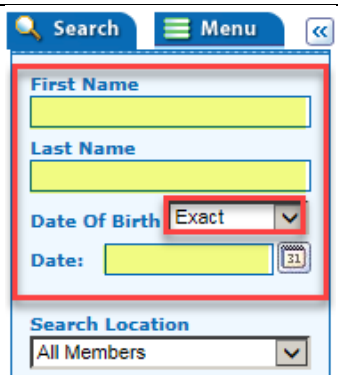
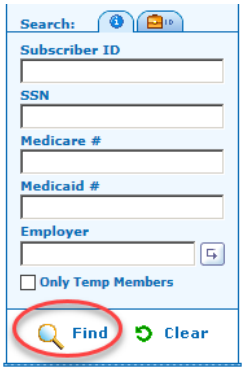


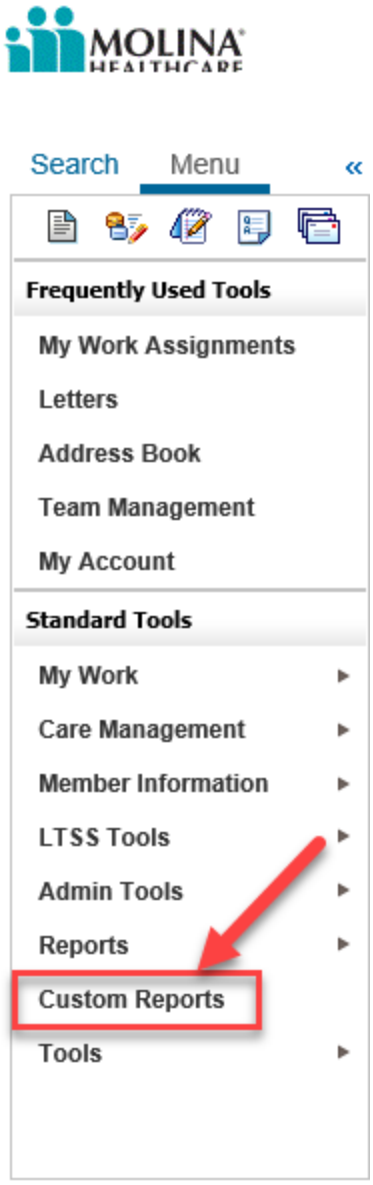
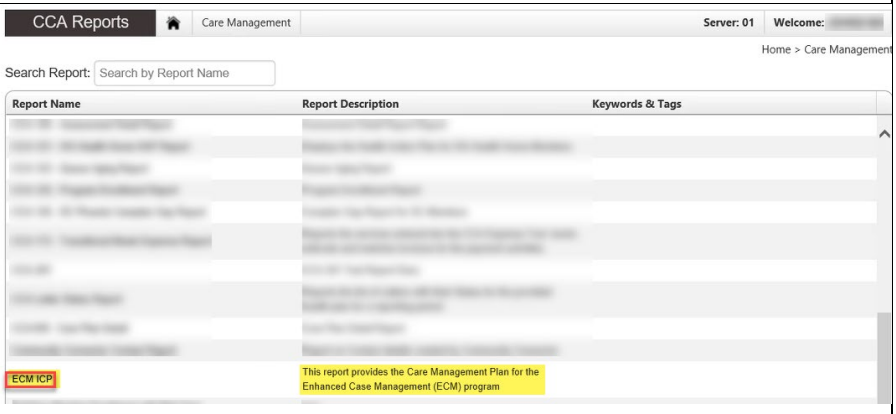
Step 4: Select **Save**	
Step 5: To check your **Tasks,** click on the check mark at the top-right-hand corner or the Home icon at the top-right-hand corner.	 
Step 6: When the Task has been completed, the user can click on the **Task** and choose **Mark Complete**	

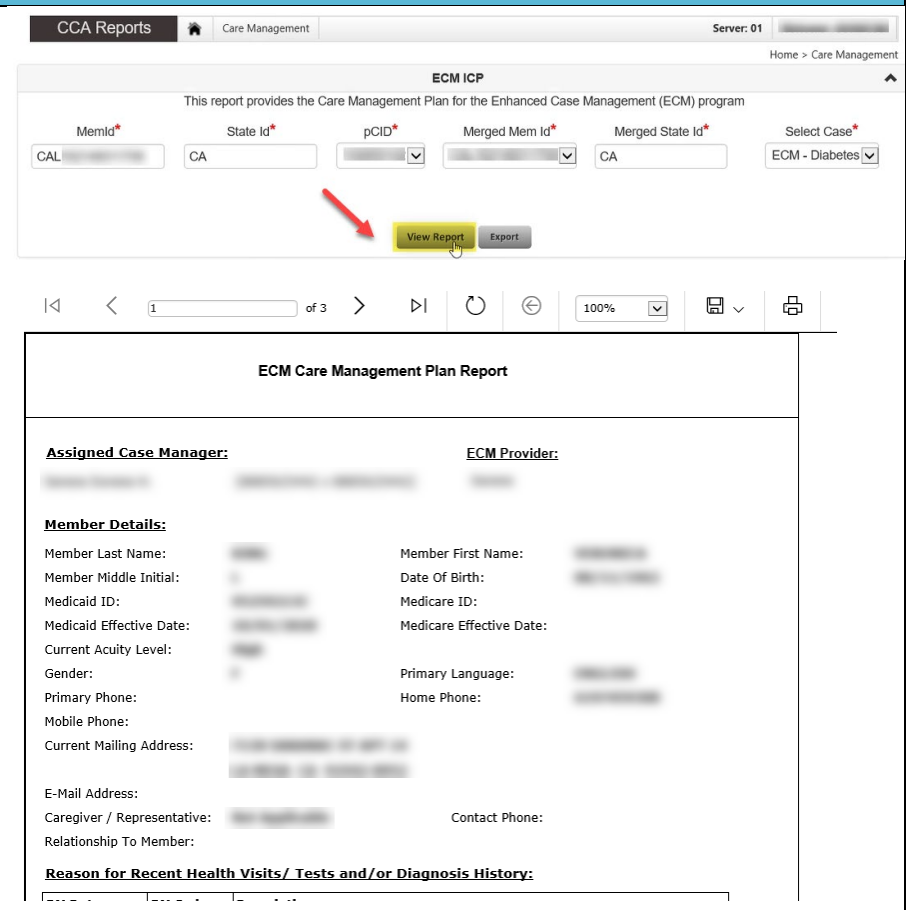
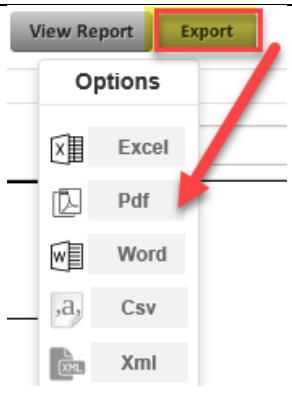
CCA Custom Report- ICP Report

If the ECM LCM is unable to attach the care plan to the care plan letter (see steps ***Generating Letters in CCA and Attaching ECM Care Plan Letter to the ECM Care Plan below***) and gets an error message: *The system is not able to pull care plan report, please attach manually*, the ECM LCM will need to pull the care plan manually, also known as the ICP Report. Member consent must be obtained in the care plan to access and pull the ICP Report. The ECM LCM must provide a copy of the care plan to the member and the member's PCP after developing it and when it gets revised.

Follow the steps below to pull the ICP Report from CCA:

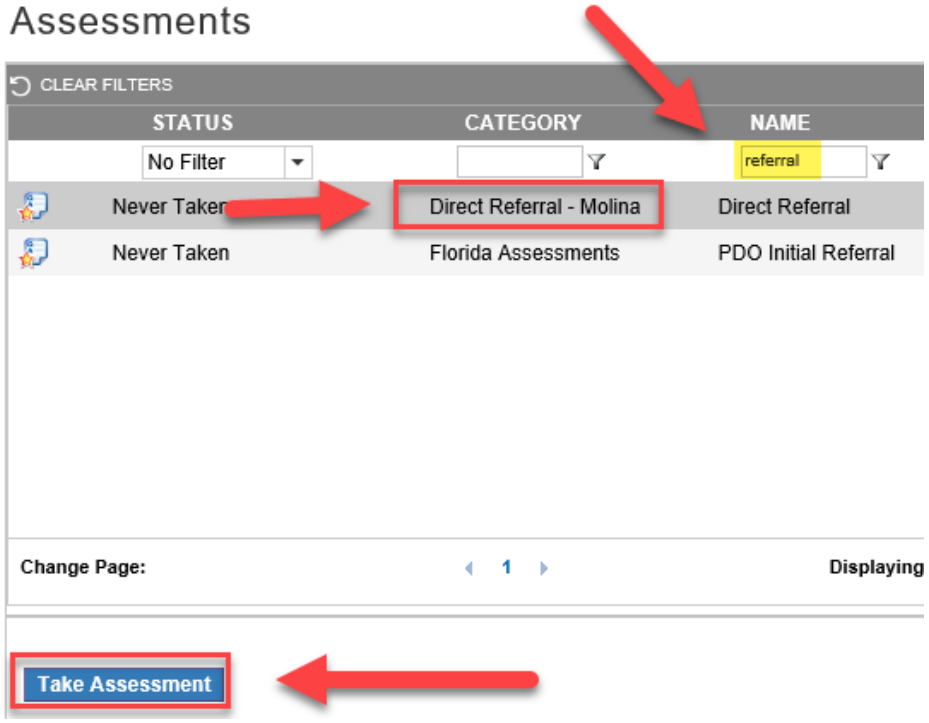
INSTRUCTIONS	SCREENSHOT
Access CCA and click on the **SEARCH** tab to enter the member's full name.	
Type in the member's **FIRST NAME**, **LAST NAME**, and **DATE OF BIRTH** (selecting **EXACT** DOB from the drop-down box), then select **FIND** Alternate Search Criteria are available using the following: • Medicaid # • Employer = CA	 
Search Results will populate members' information. Select the member by clicking on the member's name. This will bring the member "into focus."	

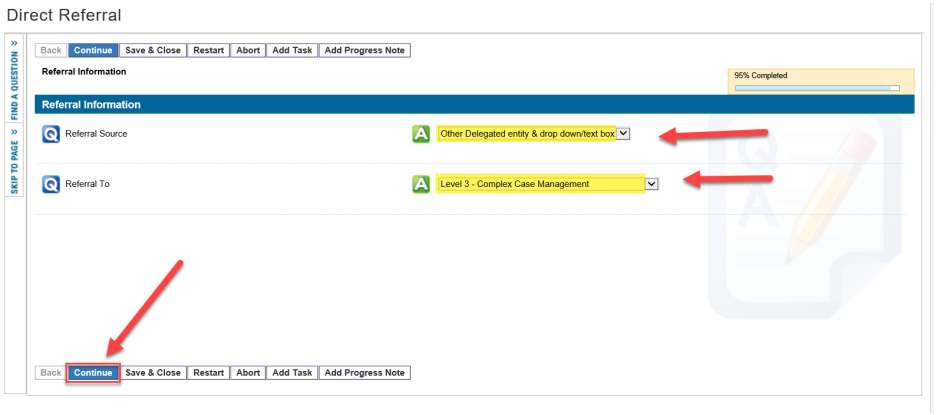
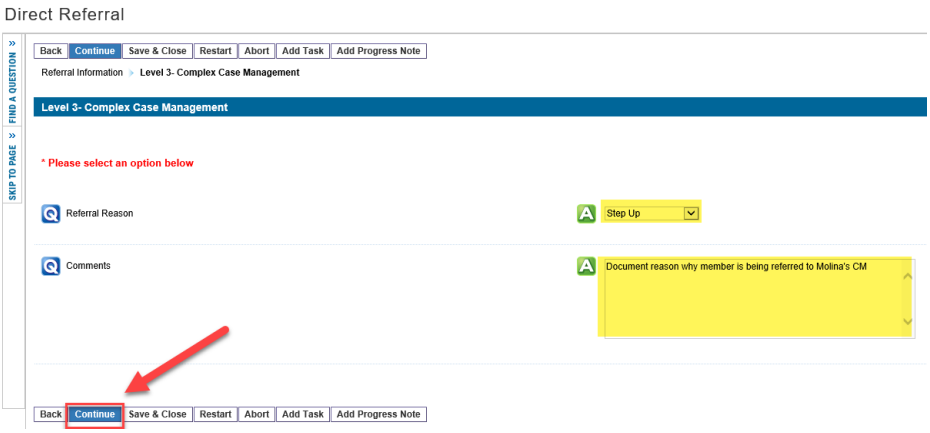
INSTRUCTIONS	SCREENSHOT
Select the **Custom Reports** module:	
Select **ECM ICP**:	

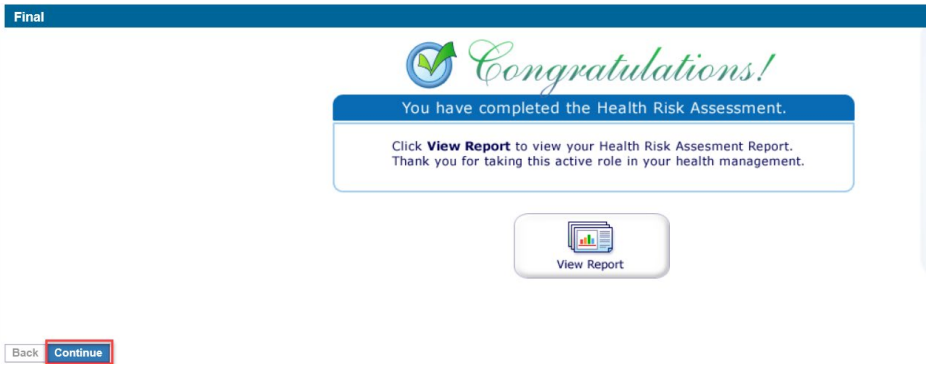
INSTRUCTIONS	SCREENSHOT
Select ***View Report,*** and the report will appear:	
Click **Export** and **PDF**. Mail this copy of the care plan to the member and the member's PCP, along with the appropriate care plan letter.	

Direct Referral to Molina's Case Management

For members that need to be downgraded to a lower level of care, the ECM LCM is required to submit a direct referral to Molina's Case Management. Follow the steps below to submit the referral to CCA:

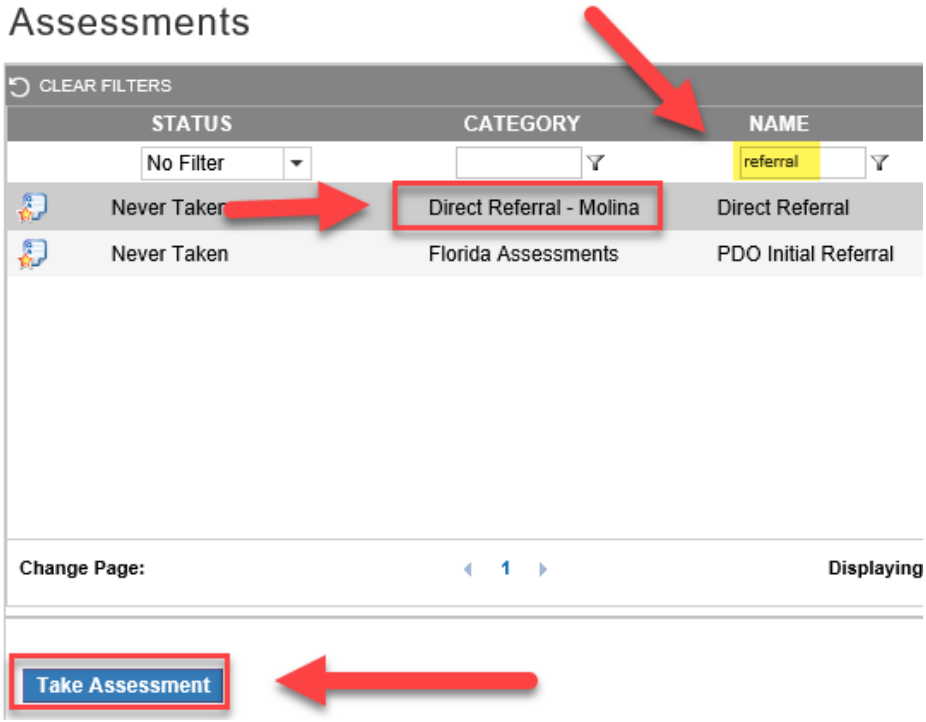
INSTRUCTIONS	SCREENSHOT
Step 1: Access the "**Assessment**" Module in CCA (member should already be in focus) There are multiple ways to access Assessments; the shortcut is displayed.	
Step 2: Choose Under Name, type in referral to filter the list Bring in focus Direct Referral – Molina and select: Take Assessment Or Retake if it was previously completed. Retake Assessment	

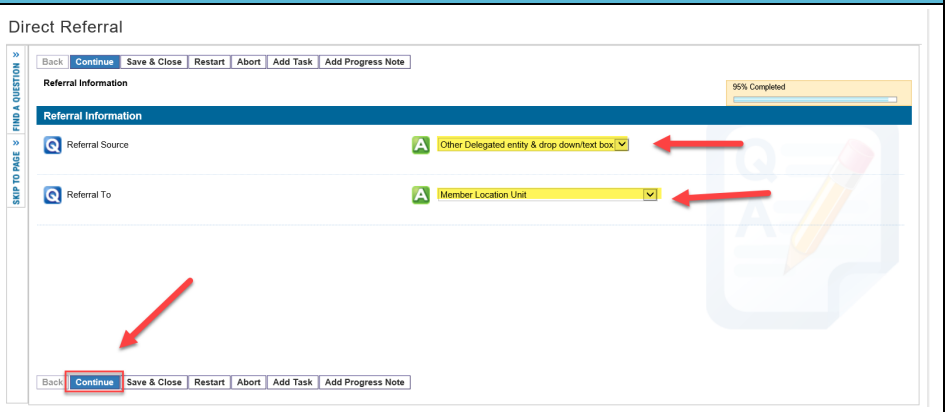
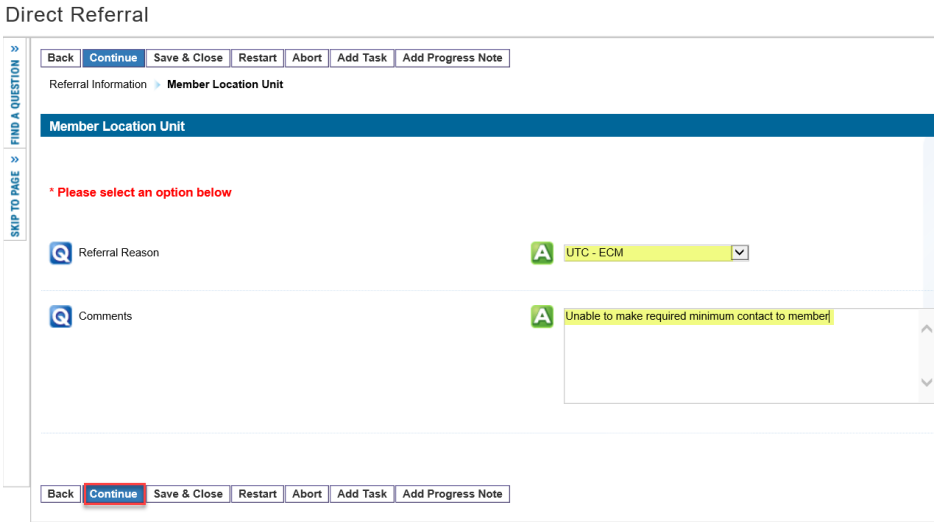
INSTRUCTIONS	SCREENSHOT
Step 3: Fill out as shown Click Continue	
Step 4: Fill out as shown: Click Continue	

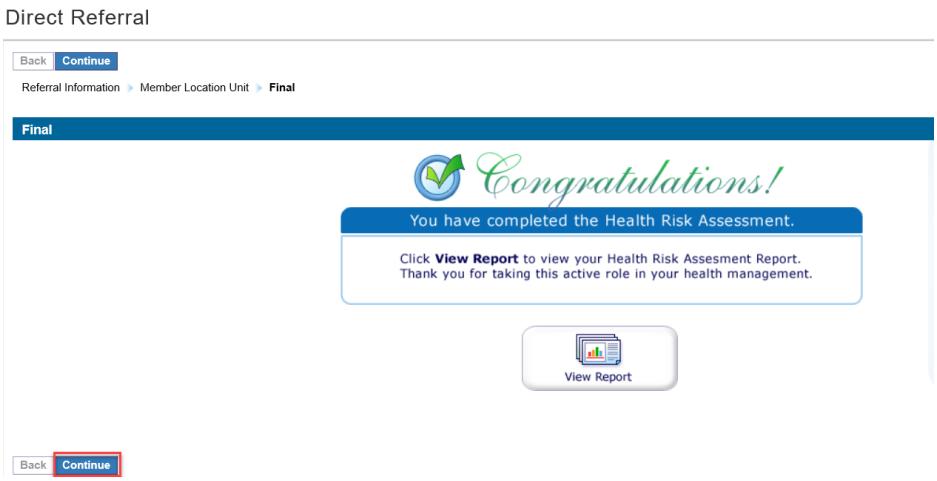
INSTRUCTIONS	SCREENSHOT
Step 5: The referral to Molina's CM has been submitted. Click **Continue** Please ensure you also complete an ECM Disenrollment form and indicate the reason for disenrollment: *Member is ready to transition to a lower level of care*	

Direct Referral to Molina's Member Location Unit

Send a direct referral to the Molina Member Location Unit for help locating UTC members without sufficient contact information. Members will be routed to Molina's Member Location Unit for assistance in finding alternate contact information. Be on the lookout for any tasks from the Member Location Unit within two business days of submitting the referral. You will be tasked regardless of their search outcome.

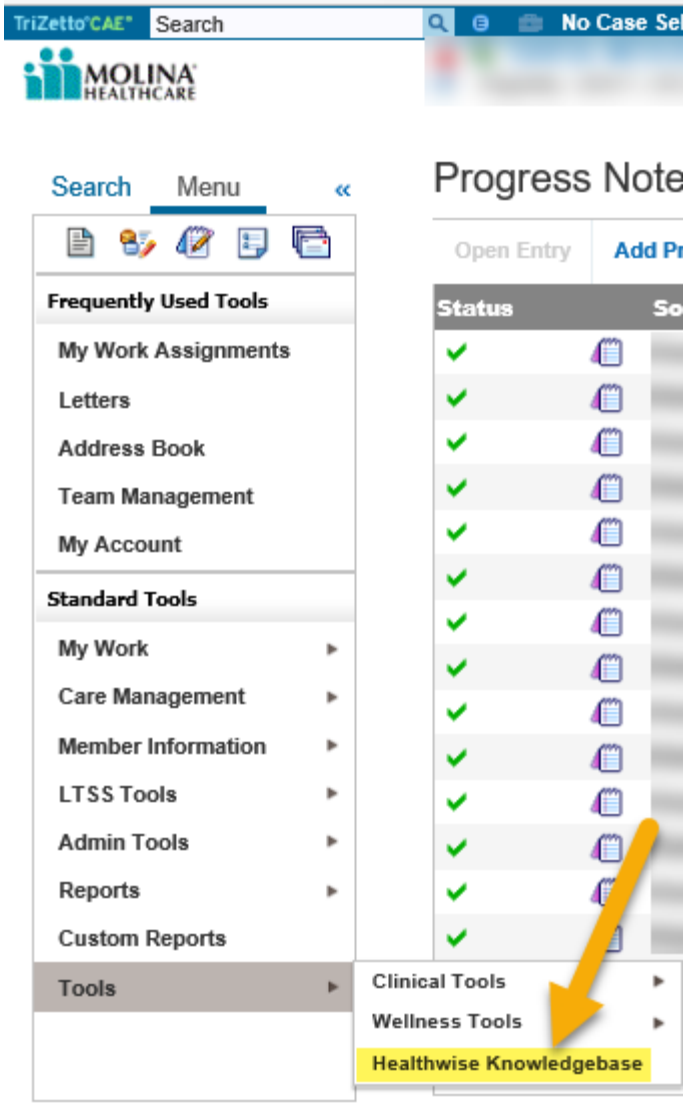
INSTRUCTIONS	SCREENSHOT
Step 1: Access the "Assessment" Module in CCA (member should already be in focus) There are multiple ways to access Assessments; the shortcut is displayed.	
Step 2: Choose Under Name, type in referral to filter the list Bring in focus Direct Referral – Molina and select: Take Assessment Or Retake if it was previously completed. Retake Assessment	

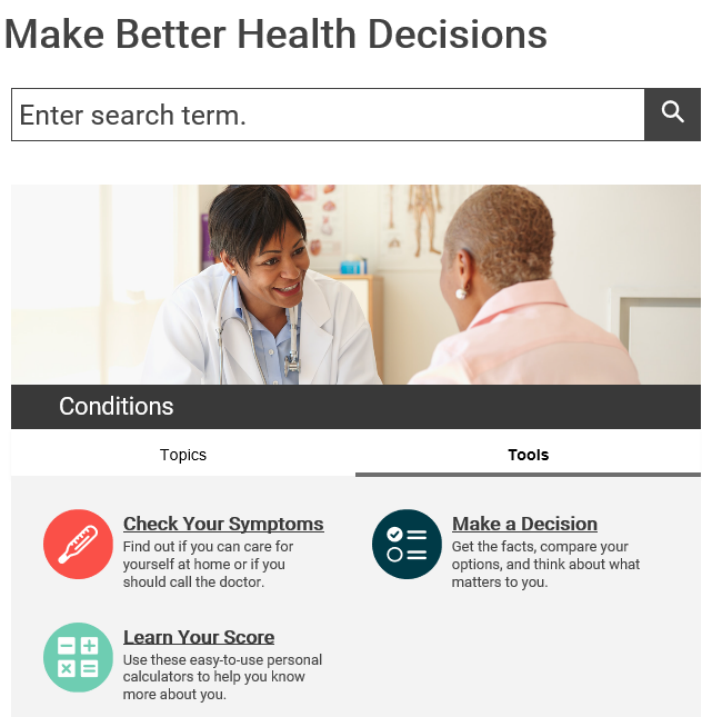
INSTRUCTIONS	SCREENSHOT
Step 3: Fill out as shown Click Continue	
Step 4: Fill out as shown: Click Continue	

INSTRUCTIONS	SCREENSHOT
Step 5: The referral to the MLU has been submitted. Be on the lookout for any tasks from the Member Location Unit. Click **Continue**	

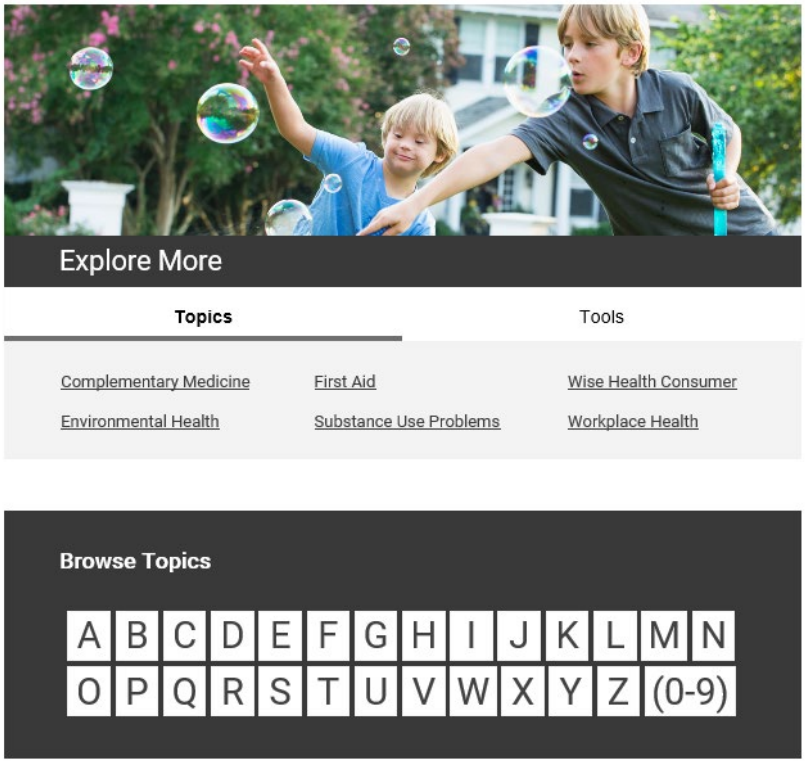
Healthwise Knowledgebase

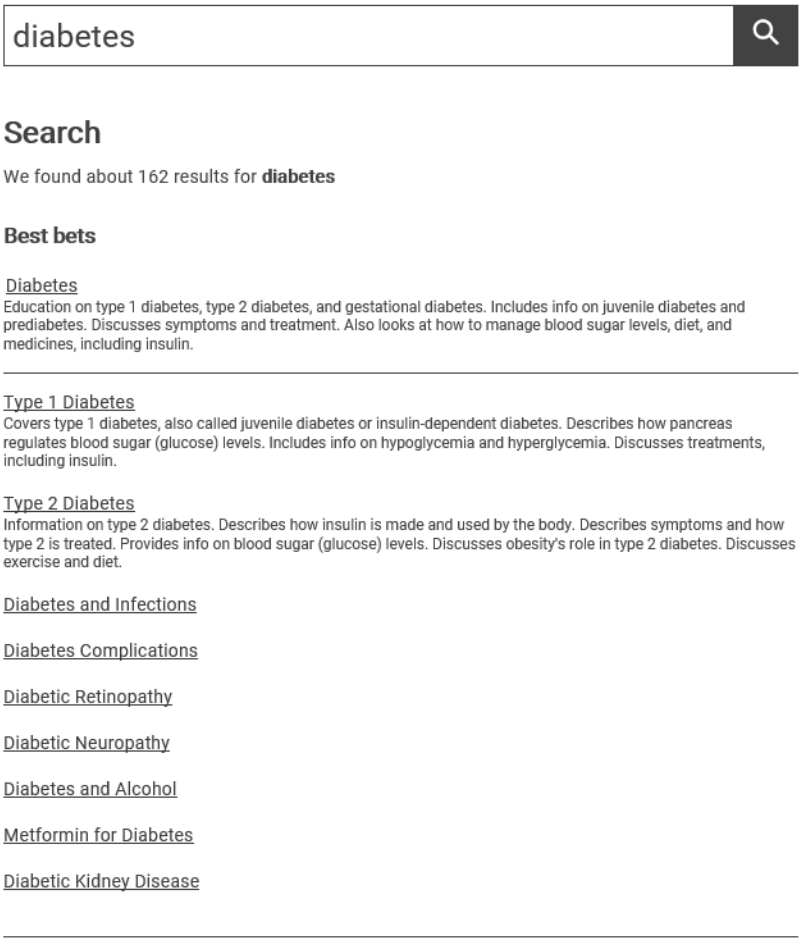
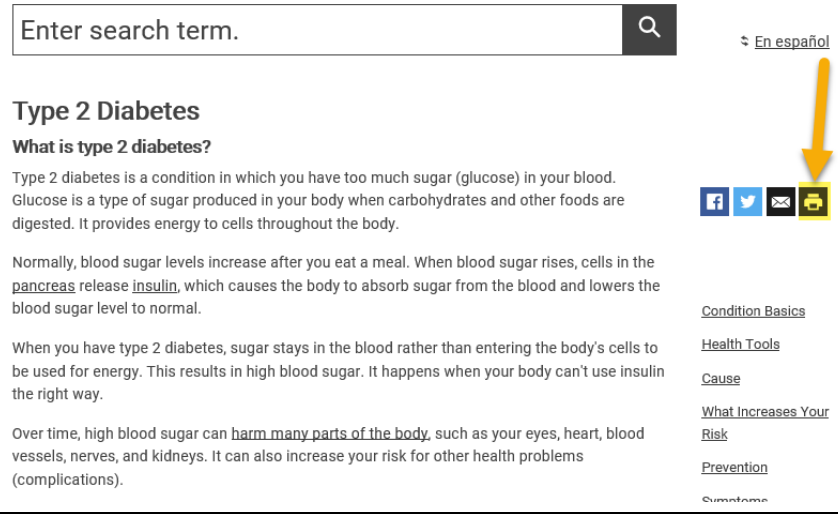
Healthwise Knowledgebase is a resource our ECM Providers can utilize to review and pull educational materials to support our members in learning and adopting healthy lifestyle choices. Follow the steps below to access Healthwise Knowledgeable in CCA:

INSTRUCTIONS	SCREENSHOT
Step 1: Under the Menu, access the Tools module Select **Healthwise Knowledgebase**	

INSTRUCTIONS	SCREENSHOT
Step 2: The following screen will appear	

INSTRUCTIONS	SCREENSHOT
	 Wellness and Prevention Topics Tools Disease and Injury Prevention Fitness and Exercise Healthy Eating Quitting Smoking Sleep Problems Weight Management  Life Stages Topics Tools Advance Care Planning Children's Health Infant and Toddler Health Men's Health Parenting Pregnancy and Childbirth Senior Health Sexual Health Teen Health Women's Health Young-Adult Health

INSTRUCTIONS	SCREENSHOT
	

INSTRUCTIONS	SCREENSHOT
Step 3: Browse or search topics of choice. See the sample in the screenshot.	
Step 4: Click on the desired link, and a webpage will appear. This information can be printed by clicking on the printer icon.	

Targeted Engagement List (TEL)

During the onboarding process, Molina's ECM Team will request the new ECM Provider's Targeted Engagement List (TEL), also known as the Member Information File (MIF), parameters (e.g., Populations of Focus they service, zip codes, Tax IDs, age, capacity, etc.). This will ensure proper member assignment for the TEL and referrals. If the ECM Provider decides to change their TEL parameters, they must inform Molina's ECM Team immediately.

ECM Providers will utilize their TEL to outreach their assigned ECM-Eligible members and will outreach all members in their TEL within five business days of receipt of the TEL. Regardless of the outcome, all outreaches need to be documented via a Contact Form in CCA. Moreover, irrespective of the outcome (e.g., the member agrees to participate in ECM, the member declines ECM, the member is not enrolled due to being unable to contact, the member does not meet any Population of Focus criteria, or the member is in a duplicative program), the ECM Provider needs to complete the ECM Enrollment Assessment in CCA.

ECM Providers are required to complete at a minimum of four attempts (non-mail attempts) and mail the ECM Generic UTC letter (for a total of five attempts) for members who are unable to be reached. ECM Providers should outreach their TEL members within five business days of receipt of their TEL and complete the five outreach attempts within 60 calendar days from receipt of the TEL. Attempts should be made on different days and times using at least three different modalities (in-person, phone, email, and text). Suppose the member is unable to be contacted (UTC) at any point prior to or after enrollment. In that case, ECM Providers are required to research additional contact information (review of available notes (auth notes, admission/discharge notes), call to PCP and pharmacy, direct referral to Molina's Member Location Unit, etc.) should be documented via a contact form in CCA with the appropriate outcome and correct UTC letter sent.

Privacy Breach

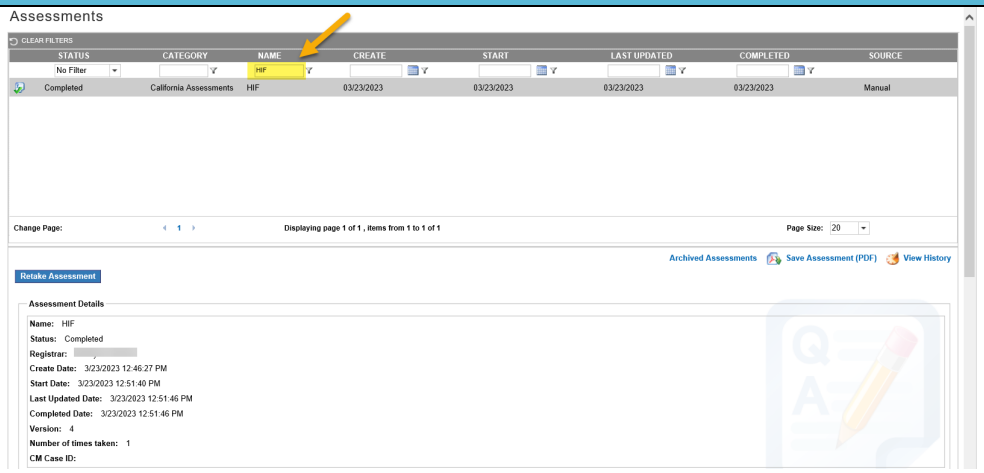
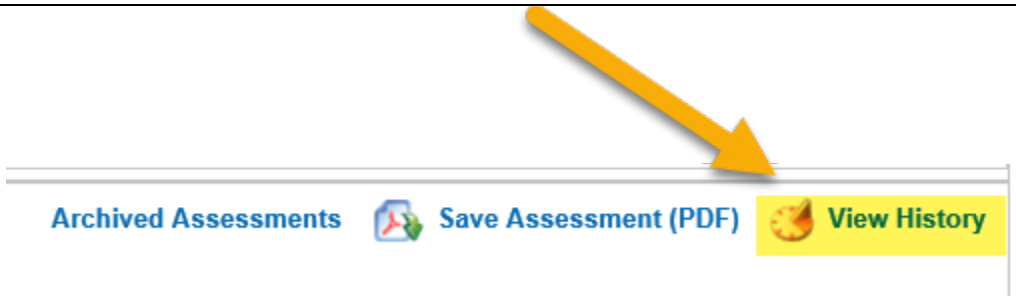
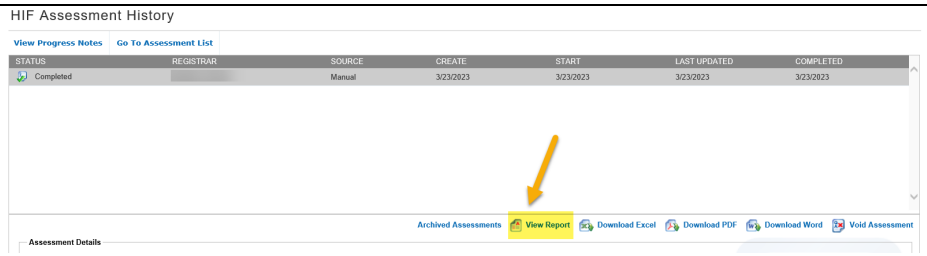
ECM Providers are only permitted to outreach, provide ECM services, and look up members in CCA assigned to their organization. If ECM Providers are outreaching, providing ECM services, or looking-up members in CCA not assigned to their organization, this is considered a privacy breach.

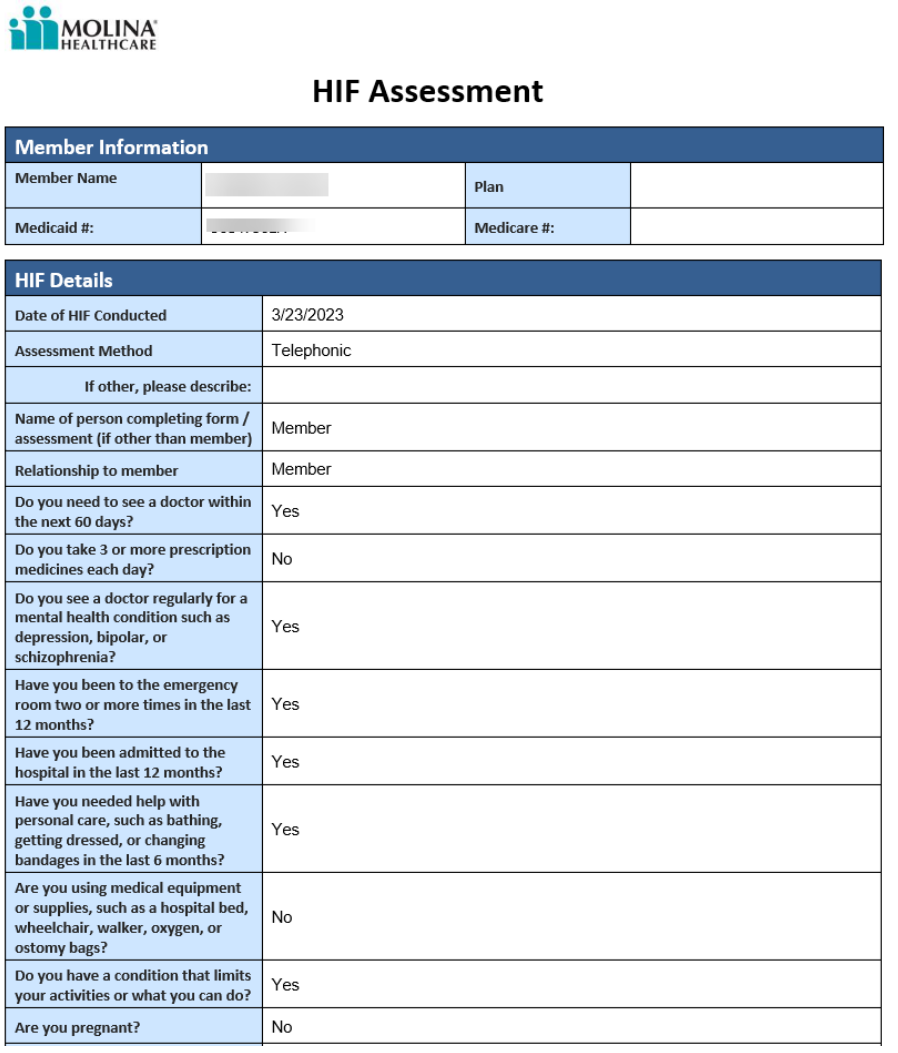
Availity

ECM Providers are required to check member eligibility through Availity before working on the member to ensure the member continues to be enrolled with our plan and a Medi-Cal beneficiary. For access and questions regarding Availity, refer to your assigned Molina PSR. In addition, prior to submitting any referrals to our ECM Team, ECM Providers should check the member's eligibility in Availity; this will avoid denying referrals for members not enrolled with Molina Medi-Cal.

Pre-Call Review

The ECM LCM is required to complete a pre-call review post-enrollment and document it via a contact form in CCA. This pre-call review includes reviewing the information found in CCA, such as the Member Dashboard, available clinical notes in CCA, and Availity. In addition to completing the pre-call review post-enrollment, ECM Providers must complete this exercise before every member outreach (to detect any patterns of care) and document these reviews via a contact form in CCA. Molina has added a new pre-call review requirement. When conducting the pre-call review, the ECM LCM must review the Assessments module in CCA and search for HIF under the Name section to see if the member completed a recent Health Information Form (HIF). The ECM LCM is required to review the HIF for any positive responses and address them with the member.

INSTRUCTIONS	SCREENSHOT
Step 1: Search for "**HIF**" in the Assessments module in CCA	
Step 2: Select **View History**	
Step 3: Bring into focus the most recent HIF assessment (if you already addressed the most recent HIF assessment, then note this in the pre-call review contact form) and select **View Report**	

INSTRUCTIONS	SCREENSHOT
Step 4: The HIF assessment will appear in a separate window. **Reminder:** The ECM LCM is to review and address any positive responses with the member. This should all be documented in a contact form(s)	

HIF Assessment

Member Information			
Member Name		Plan	
Medicaid #:		Medicare #:	

HIF Details	
Date of HIF Conducted	3/23/2023
Assessment Method	Telephonic
If other, please describe:	
Name of person completing form / assessment (if other than member)	Member
Relationship to member	Member
Do you need to see a doctor within the next 60 days?	Yes
Do you take 3 or more prescription medicines each day?	No
Do you see a doctor regularly for a mental health condition such as depression, bipolar, or schizophrenia?	Yes
Have you been to the emergency room two or more times in the last 12 months?	Yes
Have you been admitted to the hospital in the last 12 months?	Yes
Have you needed help with personal care, such as bathing, getting dressed, or changing bandages in the last 6 months?	Yes
Are you using medical equipment or supplies, such as a hospital bed, wheelchair, walker, oxygen, or ostomy bags?	No
Do you have a condition that limits your activities or what you can do?	Yes
Are you pregnant?	No

INSTRUCTIONS	SCREENSHOT

If yes, are you currently seeing a doctor for this pregnancy?	
Do you see a doctor regularly for a chronic medical condition?	Yes

Medical Conditions	
Asthma	Yes
Cancer	No
Cystic Fibrosis	No
Diabetes	No
Heart Problems	No
Hepatitis	No
High Blood Pressure	Yes
HIV or AIDS	No
Kidney Disease	No
Seizures	No
Sickle Cell Anemia	No
Tuberculosis	No
Other	Saw doctor 2 years ago but has not since moving and becoming homeless Chronic Depression, PTSD, Anxiety, OSA, Nightmare disorder

ECM LCM Credentials and Confirmation of their Expertise and Skills

The ECM LCM must document their credentials and confirmation of their expertise and skills to serve the individual member in a culturally relevant, linguistically appropriate, and person-centered manner post-enrollment via a contact form in CCA within **five business days** from assigning an ECM LCM to the member. If there's a change in the ECM LCM assignment, the new ECM LCM must do the same exercise within **five business days** from the member assignment.

Members Aging Out

Youth members approaching age 21 need to be assessed against the Adult Populations of Focus criteria. Molina's ECM Team will send reminders to our ECM Providers once this time approaches. The ECM LCM must discuss the Adult Populations of Focus criteria with the member, document the discussion in a contact form in CCA, note the Adult Population(s) of Focus criteria the member qualifies, and inform Molina's ECM Team. Molina's ECM Team will note the new Adult Populations of Focus in their system. If a youth member does not meet an Adult Populations of Focus criteria, the ECM Provider should apply the graduation criteria to determine when the member is ready to be disenrolled from ECM.

ECM Referral Forms

Molina accepts all ECM referral forms. Molina's latest ECM Referral template is located on Molina's website. When referring a member to our ECM Program, ensure the referral form is completed in its entirety to avoid delays. Referrals will be processed within five business days of receipt. Urgent referrals will be processed within 72 hours; indicate in the subject line if you have an urgent referral. Molina's ECM Team is responsible for reviewing the referral and assigning an ECM Provider to the member. Molina's ECM Team will inform the referrer if the referral was approved or denied.

Change to the Referral Process

We noticed that numerous ECM Providers were not completing the ECM Enrollment Assessment for members they were referring to the program. Thus Molina's ECM Team altered the referral process once again. Molina's ECM Team will complete the ECM Enrollment Assessments **for all referrals**. The assigned ECM Provider will be notified once this has been completed and is responsible for outreaching the member to start providing ECM services within **five business days** of notification of member enrollment. Reminder, if a member does not receive ECM services and there are no contact forms in CCA evidencing ECM services were provided, the ECM Provider will not receive payment.

Physician Certification Statements

Per APL 22-008, Health Plans are required to obtain a Physician Certification Statements (PCS) form *(found on Molina's public website under **Transportation**:* https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx **)** demonstrating members need for Non-Emergent Medical Transportation (NEMT). ECM LCM is to reach out to the member's Provider/Facility and request that they complete the authorization request form for NEMT Services. We ask that the ECM LCM make up to three (3) attempts to contact the provider/facility. Both providers must complete the PCS if the member has multiple standing orders. The Provider needs to complete the PCS form and submit the completed form to American Logistics (AL) via fax at (877) 282-8441 or by email at MolinaFax@AmericanLogistics.com. The ECM LCM will create a contact form in CCA with the subject line "NEMT PCS outreach" and document the outcome of the contact. The ECM LCM needs to elaborate on any other member findings/discussions held with the provider, as applicable (e.g., "Contacted <Provider/Facility>, educated on PCS form for NEMT mode of transportation for the members standing order. The provider reported understanding and agreed to complete and submit the PCS form to AL. Provided the members' Provider with the PCS form"). New guidance: A PCS Form is also needed for ambulatory door-to-door service transportation; refer to the form for more information.

Molina's ECM Team might also come across some members with outstanding PCS Forms and will contact our ECM Providers for support on this matter and request updates.

For Non-Medical Transportation (NMT), a PCS form is not needed. The ECM LCM should indicate in the request to American Logistics when setting up the appointment that it's non-medical.

Contact Forms & Attempts

ECM Providers are required to provide ECM services every month to our members. Documentation should reflect the development and member consent of a schedule to timely follow-up/communicate with the member to monitor progress and compliance with case management plans and goals and is modified based on the member's identified needs. Outreaches should consist of varying modes of contact and at different times of the day. ECM Providers are required to document ongoing care management of the member's needs in a contact form with the correct purpose of contact/outcomes, clear notes, and length of contact (e.g., coordination for medication/DME needs, scheduling of appointments, appointment reminders, accompaniment to appointments, supply of health management education materials, coordination of transportation, assistance to SDOH needs, strategies to address avoidable admissions, etc.).

Capitation will start once an ECM Provider completes the ECM Enrollment Assessment and the member agrees and qualifies for the program. Payment post-enrollment depends on the ECM Provider providing continuous monthly ECM services, and complete and accurate data entry into Contact Forms in CCA for every service and/or interaction with the member and on behalf of the member, regardless of the outcome of the contact. ECM Providers will not receive capitation for months they do not provide ECM services. CCA documentation is used in lieu of your organization submitting claims, encounters, or invoices, and it's critical that our ECM Providers enter this information timely and accurately. To avoid capitation issues, we ask that you always complete a quality review of your

contact forms before saving them in CCA and enter them in CCA as soon as possible, no later than 30 days from the date of service/attempt.

For enrolled members who are later identified to be unable to contact, ECM Providers are required to complete at a minimum three non-mail attempts and one mail attempt (mail the Post-Opt in UTC letter) for a total of **four attempts within the same month**. If the member continues to be unable to contact at the end of the month, our ECM Providers will need to disenroll the member by completing the Disenrollment Form in CCA no later than the last day of the month. See the example below of a member that was UTC post-enrollment, and the ECM LCM exhausted the minimum required outreach attempts:

I. *A member was enrolled on 2/27/2023.*
II. *ECM LCM attempts to contact the member on 3/1/2023, 3/8/2023, and 3/15/2023, and the member is unable to contact during all three outreaches.*
III. *ECM LCM mails Post-Opt in UTC letter on 3/22/2023.*
IV. *The member does not contact ECM LCM within a week of the letter being mailed.*
V. *ECM LCM proceeds with disenrolling the member on 3/29/2023.*

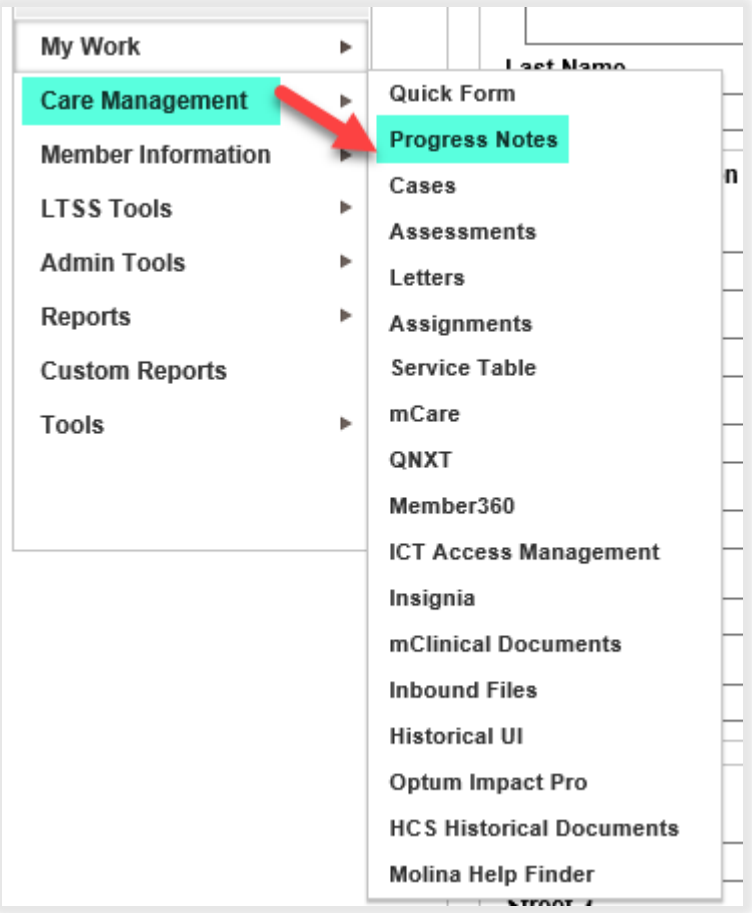
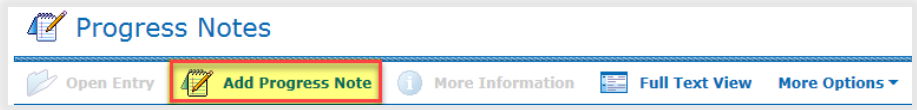
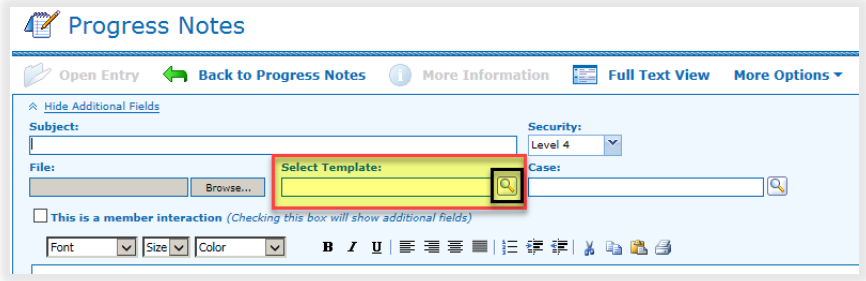
For homeless enrolled members who cannot contact us, we understand the challenges with getting a hold of these members. The same requirement applies; however, instead of disenrolling by the end of the month, our ECM Providers will need to extend the outreaches to the 2nd month, and if the member continues to be UTC by the end of the 2nd month, proceed with disenrolling the member by completing the Disenrollment Form in CCA no later than the last day the 2nd month. See the example below:

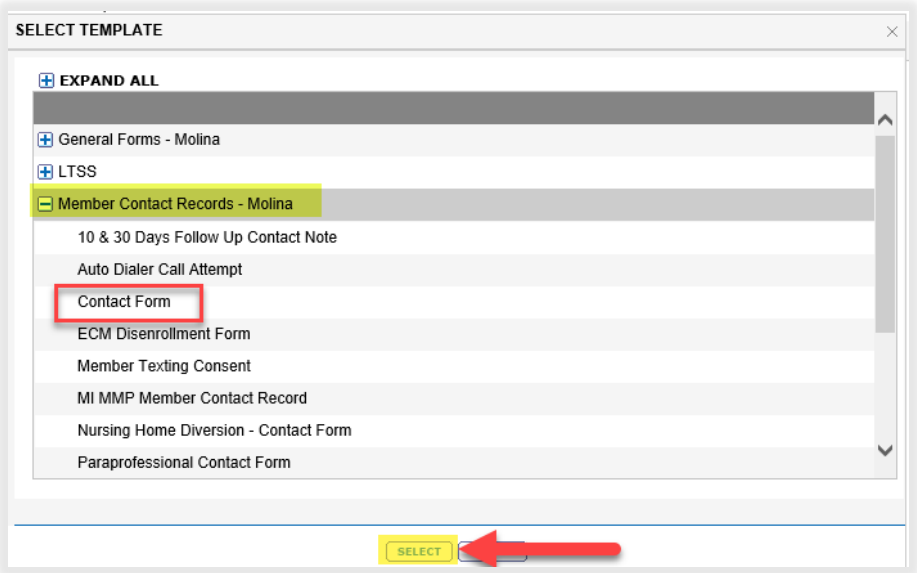
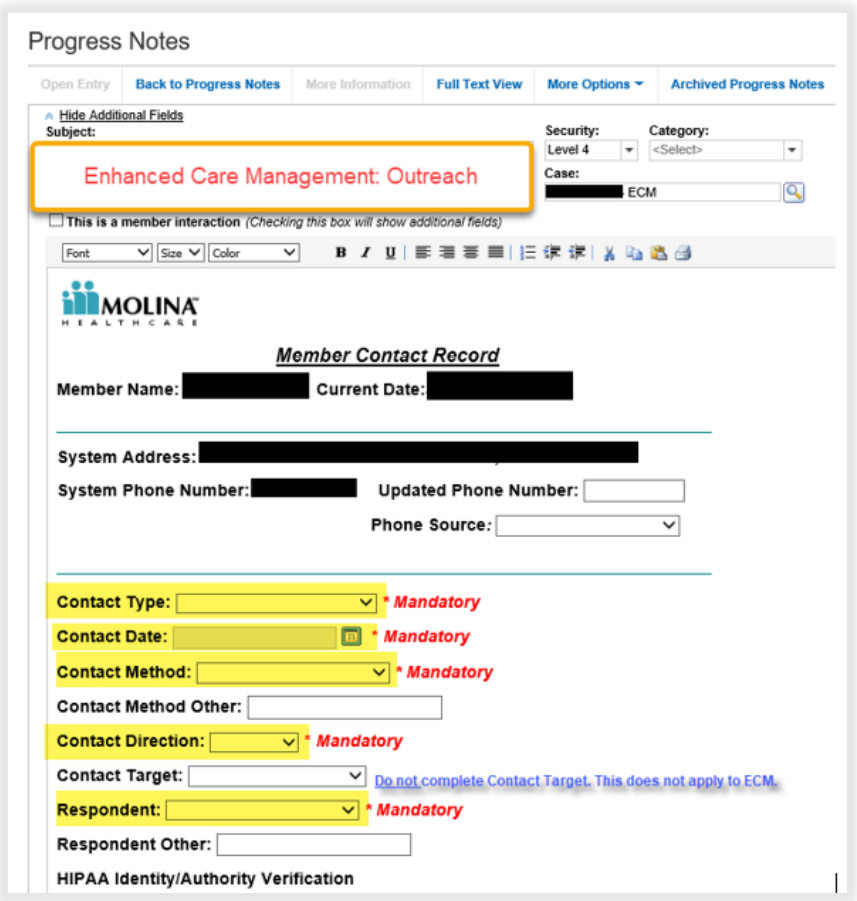
I. *A homeless member was enrolled on 2/27/2023.*
II. *ECM LCM attempts to contact the member on 3/1/2023, 3/8/2023, and 3/15/2023, and the member is unable to contact during all three outreaches.*
III. *ECM LCM **attempts** to mail Post-Opt in UTC letter on 3/22/2023 to address on record.*
IV. *A member does not contact ECM LCM within a week of a letter being mailed.*
V. *ECM LCM attempts to contact the member on 4/3/2023, 4/10/2023, and 4/17/2023, 4/24/2023 (4th attempt does not need to be a UTC Letter, use another mode of contact), and the member is unable to contact during all four outreaches.*
VI. *ECM LCM proceeds with disenrolling the member on 4/28/2023.*

Refer to the ***Targeted Engagement List section*** for outreach requirements for TEL members.

Below are the steps for accessing the Contact Form in CCA and how to complete it:

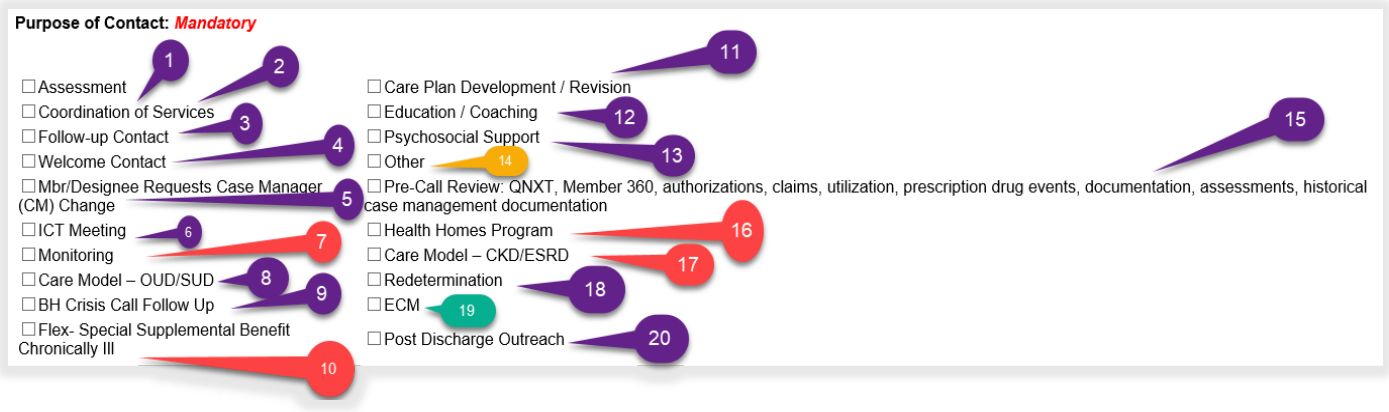
INSTRUCTIONS	SCREENSHOT
Step 1: Access the Progress Notes Module in CCA There are multiple ways to access Progress Notes à Contact Forms; the shortcut is displayed. **Please use one contact form per provider or member (or member's representative) contact/attempt.**	 Or….

INSTRUCTIONS	SCREENSHOT
	
Step 2: Click on **Add Progress Note** Under **Select template**, click the magnifying glass to search for the ***Contact Form*** template:	 

INSTRUCTIONS	SCREENSHOT
Click **SELECT**	
Step 3: Fill out the contact form as appropriate. Scenarios: ▪ Enrollment in Enhanced Care Management ▪ Enrollment into Enhanced Care Management, Assessment, ECM Care Plan ▪ Assessment, ECM Care Plan Care Coordination **Note:** Any contact made to the member or on behalf of the member, regardless of whether the outreach was successful or not, should be documented in a contact form. Scenarios to note: If you completed an ECM Enrollment Assessment, HRA, or TOC Assessment or created/updated the care plan, or Disenrollment Form, you must enter contact forms for those interactions/services provided to the member in CCA. Failure to document properly will impact capitation and audits. **Contact Type:**	

INSTRUCTIONS	SCREENSHOT
• Initial Member- we are <u>not</u> using this option. <u>Do not select this option.</u> • General Contact- we primarily use this when outreaching the member. • Provider/Agency- when outreaching to Provider or Agency. • Interdisciplinary Care Team- an individual(s) who is supporting the member's care, such as a caregiver or social worker. **Contact Date:** the date of service/when the interaction happened; we want this to be documented in real-time. When you make a call to the member, subsequently complete the contact form. **Contact Method:** use the option that best fits your encounter with the member. The most frequent contact methods include phone or Face to Face- Home. **Contact Direction:** either select inbound if someone called you or select outbound if you called them. **Respondent:** is the individual you intended to reach. For example, if you couldn't reach the member, you would still select Member here. Member is the option commonly selected here. **HIPAA Identity/Authority Verification:** When we speak to the member or speak to someone on behalf of the member, we must verify HIPAA. You are required to check off two items from this list. Normally we check off the address and date of birth. However, if you couldn't reach the member, you would check off N/A- UTC.	***(Mandatory - Select Minimum of 2 items if contacted):*** ☐ Address ☐ DOB ☐ CCA Case #, if available ☐ Member ID # ☐ N/A - UTC

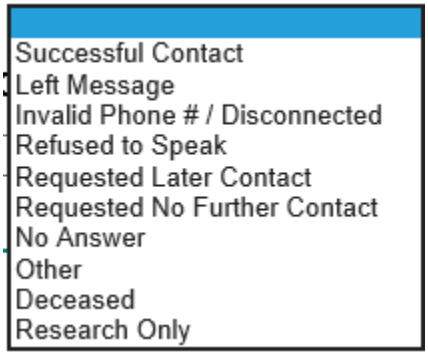
Purpose of Contact: Ensure you select the "*ECM*" and a valid service. **"ECM" alone or "ECM" with "Other" are not valid options.** "ECM" with a valid service and "Other" is fine.



1. **Assessment**: check-off this option if the outreach was intended for completion of a Health Risk Assessment (HRA) with the member or if the ECM Provider could complete the Health Risk Assessment (HRA) with the member.
2. **Coordination of Services**: check-off this option if you intended or were able to provide/arrange care coordination services for the member
3. **Follow-up Contact:** check-off this option if you intended or could follow up with the member (or following up with a Provider/Agency). If you check this option, check an additional ECM service. When following up with a member and/or Provider/Agency, an ECM service, such as Coordination of Services, should also be provided. Also, select this option when following up with members who have called the Nurse Advise Line (NAL), the ECM Team will inform you when this happens.
4. **Welcome Contact**: check off this option if you are contacting a TEL member for enrollment into ECM, successfully enrolling a member into ECM, or mailing the Welcome Letter.
5. **Mbr-Designee Requests Case Manager (CM) Change**: If you have any members who request to change their assigned ECM LCM, please check off this option.
6. **ICT Meeting**: check-off this option for Interdisciplinary Care Team meetings. For example, if members are approved for Community Support, ICTs should occur between the ECM and CS providers.
7. **Monitoring**: Do not use this option; not intended for ECM.
8. **Care Model- OUD/SUD**: Do not use this option; not intended for ECM.
9. **BH Crisis Call Follow-up**: check-off this option when following up with members who have called the BH Crisis Line; the ECM Team will inform you when this happens.
10. **Flex-Special Supplemental Benefit Chronically Ill**: Do not use this option; not intended for ECM.
11. **Care Plan Development/Revision**: check-off this option when you create or revise the member's care plan and when you discuss the care plan with the member.
12. **Education / Coaching:** check-off this option if you are educating or coaching the member.
13. **Psychosocial Support:** check off this option if you provide the member with psychosocial support.
14. **Other:** you can check off this option only if you check off another valid service, such as Coordination of Service. Other and ECM are not acceptable on their own. Check others if the rest of the options do not fit the outreach.
15. **Pre-Call Review:** check-off this option if you reviewed the Member Dashboard in CCA, Availity, etc. This exercise needs to happen after the member has been enrolled into ECM and the ECM Provider is ready to provide ECM Services to the member. This needs to be completebefore member outreach.

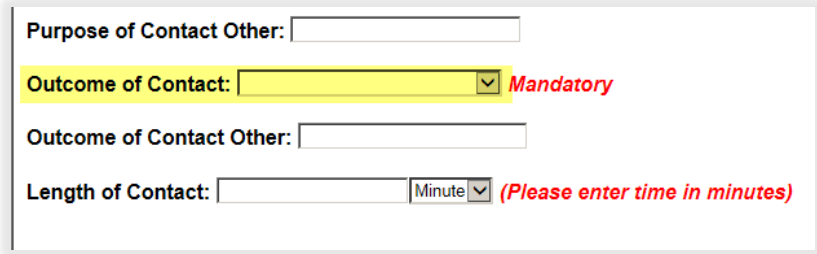
16. **Health Homes Program:** Do not use this option; not intended for ECM.
17. **Care Model- CKD/ESRD:** Do not use this option; not intended for ECM.
18. **Redetermination:** check-off this option if you support the member with their Medi-Cal redetermination paperwork.
19. **ECM**: this option should always be checked-off along with a valid service.
20. **Post Discharge Outreach**: check off this option if you are completing a Transition of Care Assessment with the member (after the member has been discharged from the hospital) or if you visited the member.

The outcome of Contact:



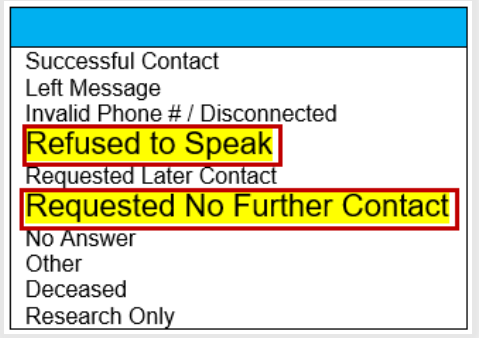
Outcome of Contact correlates with the Purpose of Contact. For example, if you check-off Assessment & ECM under Purpose of Contact and you select Successful Contact under Outcome of Contact; reporting will indicate that a CA HRA was completed.

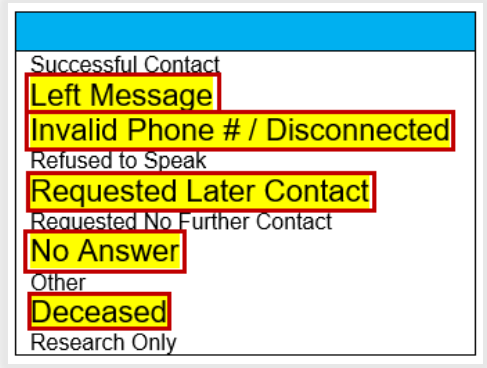
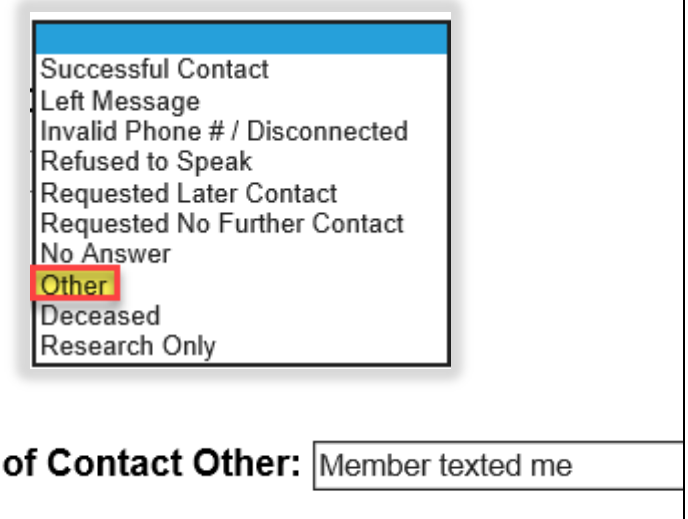
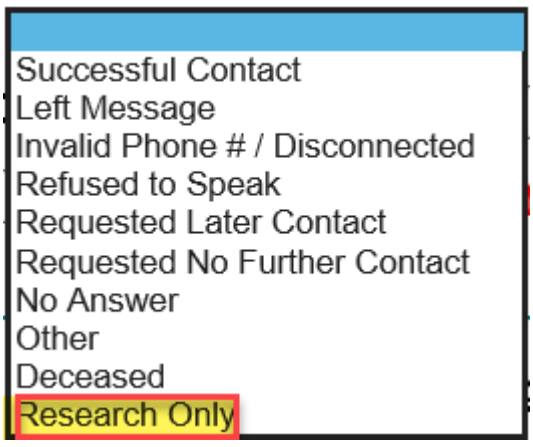
Another scenario to consider, you intended to call the member to complete an HRA, however, the member only wants to focus on getting their prescription filled and you went ahead and called the pharmacy. In this scenario, the purpose of contact **should not** have Assessment checked-off, and instead have Coordination of Services checked off along with ECM.

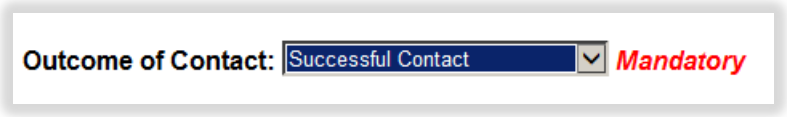
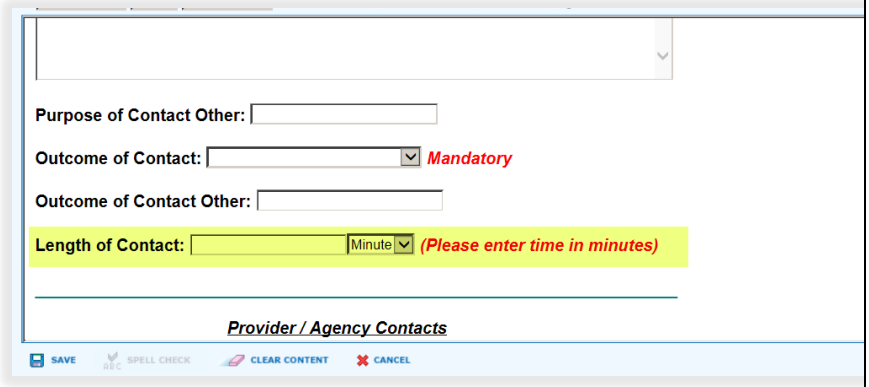
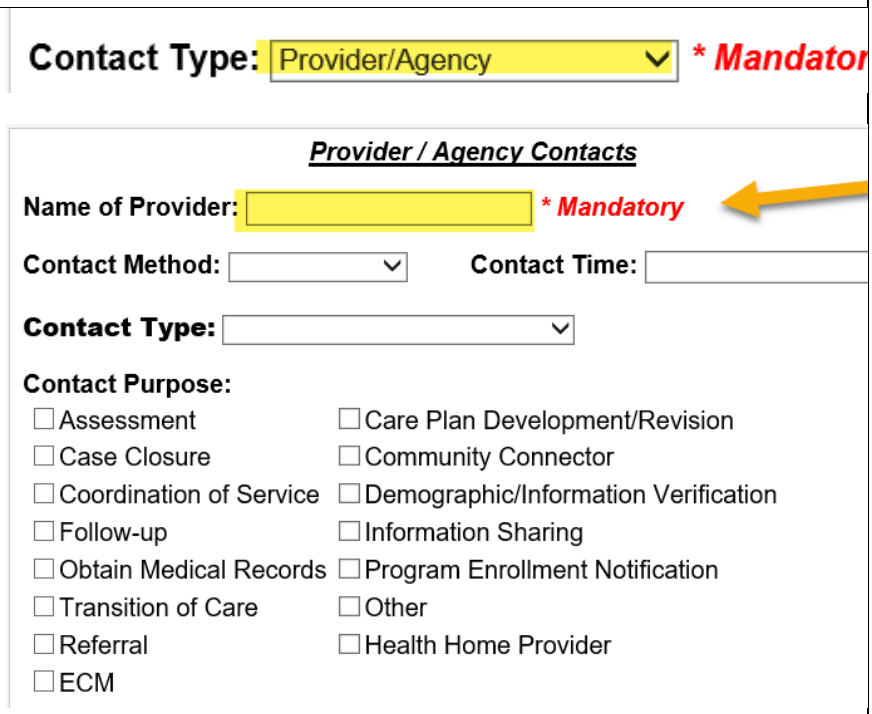


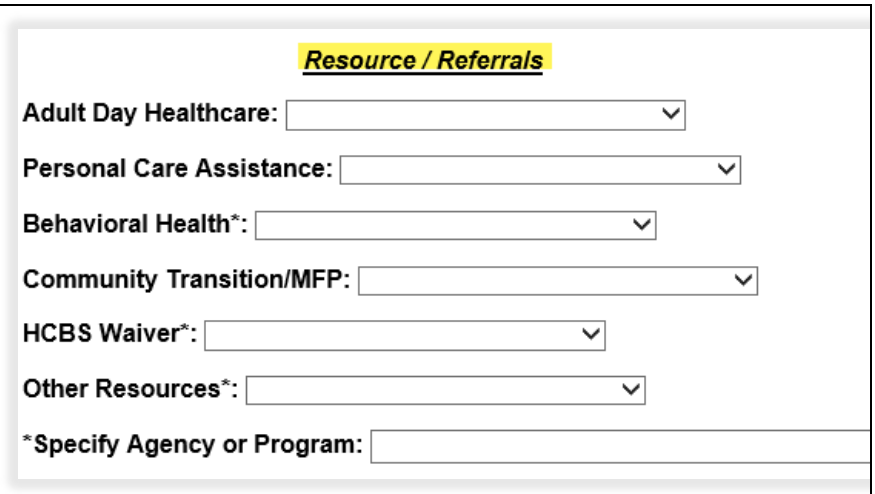
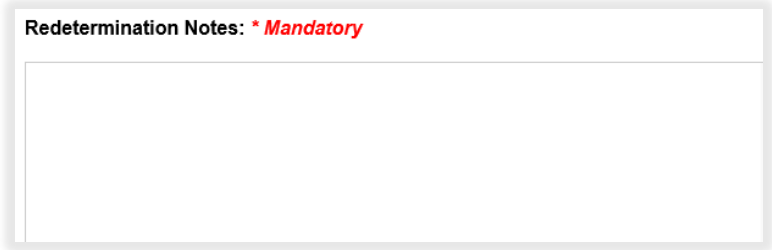
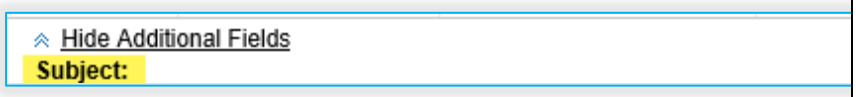
If Member declines (below are decline outcomes of contact), provide a narrative for the reason for decline.

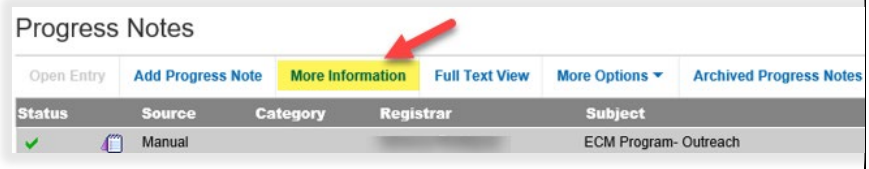
- **Refused to Speak**- scenario: *member hanged up on you, doesn't want to answer your questions.*
- **Requested No Further Contact**- scenario: *I'm not interested, please don't call me.*



If Member is UTC, choose an outcome that best supports your contact attempt. • Left message- left voicemail • Invalid Phone # / Disconnected- Member's phone # is invalid/disconnected • Requested Later Contact- scenario: *my priority right now is not the HRA, it's my medication, please call me back tomorrow* • No Answer- voicemail is not set-up • Deceased- the member passed away. If member is deceased, document who you spoke to in relation to the member, how the information was obtained, and date of passing.	
For Inbound Texts & Inbound Voicemails, select "Other," and indicate under the Outcome of Contact Other:	
ECM Providers are now able to select "Research Only" when conducting research and when documenting the Pre-Call Review. If selecting this option, make sure to also select "ECM Provider" under Respondent.	

Successful calls,	 *** Please NOTE: Successful contact should only be selected when the purpose of the call was successfully completed. Examples: Member accepts the program enrollment, you are able to initiate/continue/complete the HRA, there are care plan developments/actions/updates, any type of care coordination assistance, verbal member education was completed, etc.
Be sure to include length of contact in minutes	
Complete the **Provider/ Agency Contacts** section <u>ONLY</u> if you selected Provider/Agency under the Contact Type. It will prompt you to complete the Name of Provider under the **Provider/ Agency Contacts** section.	

Complete the **Resource/Referrals section** if applicable. We use this section for tracking purposes.	
<u>The Notes section is mandatory</u> (though it's not indicated in the Contact Form template). Enter a narrative explaining the outcome of outreach. This field should NOT be left blank. Please use this area to provide a ***<u>clear picture of the outreach outcome (include all pertinent details).</u>*** **If you come across issues saving the Contact Form, please make sure not to indent when entering the narrative in the notes section.**	
Redetermination Notes section: **<u>Only enter notes</u>** here if you assisted the member with their Medi-Cal redetermination paperwork, leave blank if it does not apply.	
Change the subject of the contact form according to the outreach that was completed. Format: **ECM Program- Name of ECM Provider Outcome.**	 ECM Program - Best ECM Provider Pre-Enrollment Outreach UTC #1 11/4/22 ECM Program - Best ECM Provider Pre-Enrollment Outreach UTC #2 11/11/22 ECM Program - Best ECM Provider Enrollment ECM Program- Best ECM Provider UTC #1 12/2/22

	ECM Program- Best ECM Provider UTC #2 12/9/22 ECM Program- Best ECM Provider UTC #3 12/16/22 ECM Program- Best ECM Provider UTC #4 12/23/22 ECM Program- Best ECM Provider Mailed Post-Opt in UTC Letter (UTC #5) 12/30/22 ECM Program- Best ECM Provider Care Plan Revision ECM Program- Best ECM Provider HRA Completed
Step 4: Click **SAVE** **We recommend you review the contact form before you hit save.**	
Step 5: To Open the Contact Form you just saved, click on the entry to bring it into focus and then More Information. **You have until the end of day to make any edits to the contact form you just created. You will not be able to make edits to this form the next day.**	

Contact Form Scenarios

Below are examples of how to complete contact forms in CCA:

Scenario #1: Pre-Enrollment. ECM Provider outreached member from their TEL, and member is unable to contact (1st non-mail attempt):

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Pre-Enrollment Outreach UTC #1 3/1/23
Contact Type	General Contact
Contact Date	03/01/2023
Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	N/A- UTC
Purpose Of Contact	ECM Welcome Contact

Purpose Of Contact Other	
Outcome Of Contact	Left Message
Outcome Of Contact Other	
Length Of Contact	1
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	Attempted to reach member for enrollment into ECM on 3/1/2023, left VM. If the member does not return my call within a week, I will conduct an in-person visitation on 3/8/2023 to address this on record.

Scenario #2: Pre-Enrollment. ECM Provider outreached TEL member, and member is unable to contact (5th attempt- mail attempt):

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Pre-Enrollment Outreach Mailed Post-Opt in UTC Letter (UTC #5) 3/29/23
Contact Type	General Contact
Contact Date	03/29/2023
Contact Method	Mail
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	N/A- UTC
Purpose Of Contact	ECM Welcome Contact
Purpose Of Contact Other	
Outcome Of Contact	Other
Outcome Of Contact Other	Mailed Letter
Length Of Contact	5
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	

Specify Agency or Program	
Notes	Member has been unable to contact for the past four attempts. On 3/29/23, I mailed the ECM Generic UTC Letter to the member. If I don't hear back from the member by 4/5/23, I will complete the ECM Enrollment Assessment and indicate member was unable to contact.

Scenario #3: Pre-Enrollment. TEL member continues to be unable to contact (after 5th attempt- mail attempt). ECM Provider completes the ECM Enrollment Assessment and indicates that the member was not enrolled and unable to contact.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Member Not Enrolled due to UTC
Contact Type	General Contact
Contact Date	04/05/2023
Contact Method	Other
Contact Method Other	Completed ECM Enrollment Assessment
Contact Direction	Outbound
Respondent	ECM Provider
Respondent Other	
HIPPA Identity/Authority Verification	N/A- UTC
Purpose Of Contact	ECM Welcome Contact
Purpose Of Contact Other	
Outcome Of Contact	Other
Outcome Of Contact Other	Completed ECM Enrollment Assessment
Length Of Contact	5
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	The member continued to be unable to contact me after I mailed the Generic UTC Letter. On 4/5/23, I completed the ECM Enrollment Assessment and indicated member was not enrolled-unable to contact.

Scenario #4: Pre-Enrollment. TEL member declines participation (2nd attempt). ECM Provider completes the ECM Enrollment Assessment and indicates member declined participation.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Pre-Enrollment Outreach UTC #2 3/8/23 Member Declined
Contact Type	General Contact
Contact Date	04/05/2023
Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Welcome Contact
Purpose Of Contact Other	
Outcome Of Contact	Requested No Further Contact
Outcome Of Contact Other	
Length Of Contact	10
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	Discussed the program with the member. Member declined participation. On 3/9/23, I completed the ECM Enrollment Assessment and indicated member declined.

Scenario #5: Pre-Enrollment. ECM Provider makes 3rd attempt and is informed by member's family that member passed away (deceased). ECM Provider proceeds with completing the ECM Enrollment Assessment and will indicate member is deceased.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Pre-Enrollment Outreach UTC #2 3/8/23 Member Deceased
Contact Type	General Contact
Contact Date	03/15/2023
Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	

HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Welcome Contact
Purpose Of Contact Other	
Outcome Of Contact	Deceased
Outcome Of Contact Other	
Length Of Contact	5
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 3/15/23, I spoke to the member's sister, Jane Smith. She informed me that the member passed away on 3/1/23. On the same day, I completed the ECM Enrollment Assessment and indicated member was deceased.

Scenario #6: Pre-Enrollment. TEL member returns a phone call to ECM Provider. Member is interested in ECM, qualifies for the program, and is enrolled in ECM.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Enrollment
Contact Type	General Contact
Contact Date	04/05/2023
Contact Method	Phone
Contact Method Other	
Contact Direction	Inbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Welcome Contact
Purpose Of Contact Other	
Outcome Of Contact	Successful Contact
Outcome Of Contact Other	
Length Of Contact	60
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	

Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	Member returned my call on 4/5/23. Discussed program and confirmed eligibility with the member. The member agreed to participate and was enrolled in ECM. Member prefers in-person visits. I provided my contact information to the member and informed him I will be his assigned ECM Lead Care Manager. Member also mentioned during today's visit that he needs assistance scheduling an appointment with their PCP. I told the member I would schedule this appointment on their behalf and call them to let them know once this has been completed—I scheduled a visit for 4/8/23 to complete the HRA and develop the care plan.

Scenario #7: Post-enrollment. ECM LCM mails the Welcome Letter to the member.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Welcome Letter Mailed 4/6/23
Contact Type	General Contact
Contact Date	04/6/2023
Contact Method	Mail
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Welcome Contact
Purpose Of Contact Other	
Outcome Of Contact	Other
Outcome Of Contact Other	Welcome Letter Mailed
Length Of Contact	5
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/6/23, I mailed the Welcome Letter to the member to address the member provided.

Scenario #8: Post-enrollment. ECM LCM documents their credentials and confirmation of their expertise and skills to serve the individual member in a culturally relevant, linguistically appropriate, and person-centered manner. ECM LCM conducts a pre-call review of the Member Dashboard, clinical notes in CCA, the Assessments module in CCA for any recent HIF assessment, and Availity before visiting the member.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Pre-Call Review & Doc of Credentials 4/7/23
Contact Type	General Contact
Contact Date	04/7/2023
Contact Method	Other
Contact Method Other	Pre-Call Review and documentation of credentials
Contact Direction	Outbound
Respondent	ECM Providers
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Pre-Call Review
Purpose Of Contact Other	
Outcome Of Contact	Research Only
Outcome Of Contact Other	
Length Of Contact	30
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	I, Vanessa Rodriguez, RN, am the assigned ECM LCM to this member. I confirm my expertise and skills to serve this member in a culturally relevant, linguistically appropriate, and person-centered manner. On 4/7/23, I completed the pre-call review and reviewed the Member Dashboard, clinical notes in CCA, the Assessments module in CCA for any recent HIF assessment, and Availity. Noted member is taking Janumet and has been to the hospital five times within the last six months. Member does not have a HIF assessment in CCA.

Scenario #9: Post-enrollment. ECM LCM scheduled PCP appointment on behalf of the member.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Scheduled PCP Appt. 4/8/23
Contact Type	Provider/Agency
Contact Date	04/08/2023
Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	Medical Provider
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Coordination of Services
Purpose Of Contact Other	
Outcome Of Contact	Successful Contact
Outcome Of Contact Other	
Length Of Contact	15
Name of Provider	Clinic #1
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/8/23, I called Clinic #1 on behalf of the member to schedule an appointment for 4/23/23 at 9 am. I will follow up with the member shortly to inform the member of the appointment details.

Scenario #10: Post-enrollment. ECM LCM completed the HRA and developed a care plan with members, discussed care coordination needs, and informed the member of scheduled PCP appointment.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Developed ICP 4/9/23
Contact Type	General Contact
Contact Date	04/09/2023
Contact Method	Face to Face - Home
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB

Purpose Of Contact	ECM Assessment Coordination of Services Follow-up Contact Care Plan Development/ Revision
Purpose Of Contact Other	
Outcome Of Contact	Successful Contact
Outcome Of Contact Other	
Length Of Contact	75
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/9/23, I conducted an in-person visitation to the member's home. We completed the HRA and developed the member's care plan. Member's primary concern is diabetes, lowering sugar levels. Member also has back problems and is self-managing this health issue; this was noted in the care plan. Member needs assistance with ADLs; member has an IHSS caregiver but needs additional IHSS hours. I will submit a CS Referral today. Member consented to care plan. I informed the member that I would mail him a copy of the care plan and the care plan letter today. I will also mail this information to their PCP. We agreed that I would check in with the member every two weeks (from today's date) to ensure we are on track with care plan goals, assist with care coordination, and provide education/coaching. I also informed the member of the scheduled appointment (4/23/23 at 9 am). I will follow up with the member on 4/23/23 and discuss how the member's appointment went.

Scenario #11: Post-enrollment. ECM LCM presented the member's care plan to their Clinical Consultant. The clinical Consultant reviewed the care plan.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Clinical Consultant Review 4/10/23
Contact Type	Interdisciplinary Care Team
Contact Date	04/10/2023
Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	ECM Provider

Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Care Plan Development/Revision ICT Meeting
Purpose Of Contact Other	
Outcome Of Contact	Successful Contact
Outcome Of Contact Other	
Length Of Contact	45
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/10/23, I presented the care plan to our clinical consultant, Nadine Khan, RN. Nadine reviewed the care plan and had no additional feedback to provide. I will meet again with Nadine to discuss members' progress next month, as needed.

Scenario #12: Post-enrollment. ECM LCM mailed a copy of the Care Plan and the Care Plan letter to the member.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Mailed ICP and ICP Letter to Member 4/10/23
Contact Type	General Contact
Contact Date	04/10/2023
Contact Method	Mail
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Care Plan Development/ Revision
Purpose Of Contact Other	
Outcome Of Contact	Other
Outcome Of Contact Other	Mailed Care Plan & Care Plan Letter
Length Of Contact	5
Name of Provider	
Adult Day Healthcare	

Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/10/23, I mailed the member a copy of the care plan and the care plan letter. Will confirm with the member receipt of this information next time we meet.

Scenario #13: Post-enrollment. ECM LCM mailed a copy of the Care Plan and the Care Plan letter to the member's PCP.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Mailed ICP and ICP Letter to Member's PCP 4/10/23
Contact Type	Provider/Agency
Contact Date	04/10/2023
Contact Method	Mail
Contact Method Other	
Contact Direction	Outbound
Respondent	Medical Provider
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Care Plan Development/ Revision
Purpose Of Contact Other	
Outcome Of Contact	Other
Outcome Of Contact Other	Mailed Care Plan Letter
Length Of Contact	5
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/10/23, I mailed a copy of the care plan and the care plan letter to the member's PCP.

Scenario #14: Post-enrollment. ECM LCM called the member for follow-up, and the member was unable to contact.

Contact Form Fields	How to Complete the Contact Form Fields

Subject	ECM Program - Best ECM Provider UTC #1 4/23/23
Contact Type	General Contact
Contact Date	04/23/2023
Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	N/A- UTC
Purpose Of Contact	ECM Coordination of Services Follow-up Contact Education/Coaching
Purpose Of Contact Other	
Outcome Of Contact	Left Message
Outcome Of Contact Other	
Length Of Contact	10
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/23/23, I called the member in the morning to follow up post the member's appointment. The member didn't answer, l left a VM for the member to call me back. If the member does not call me back today, I will call the member tomorrow evening.

Scenario #15: Post-enrollment. Member has been UTC three times. ECM LCM mails the ECM Post Opt-In UTC Letter (4th attempt) to the member a week before the month ends.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider UTC #1 4/23/23
Contact Type	General Contact
Contact Date	04/23/2023
Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	N/A- UTC

Purpose Of Contact	ECM Coordination of Services Follow-up Contact Education/Coaching
Purpose Of Contact Other	
Outcome Of Contact	Other
Outcome Of Contact Other	Mailed the Post Opt-In UTC Letter to the member
Length Of Contact	5
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 5/1/23, I mailed the Post Opt-In UTC Letter to the member; the member has been UTC for the past three attempts. If I don't hear back from the member by the end of the month, I will proceed with disenrolling the member from ECM.

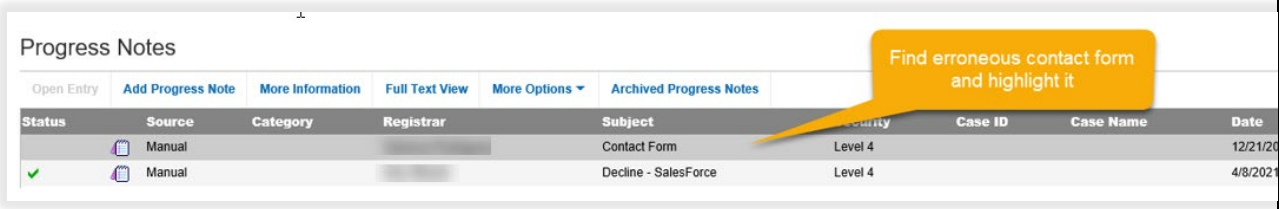
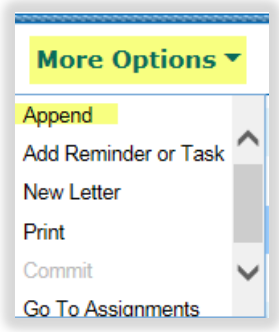
Scenario #16: Post-enrollment. Member declines participation in ECM. ECM LCM mails the ECM Post Opt-In Decline Letter before disenrolling the member from ECM.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Member Declined ECM 5/31/23
Contact Type	General Contact
Contact Date	05/31/2023
Contact Method	Mail
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Follow-up Contact Other
Purpose Of Contact Other	Mail the Post Opt-In Decline Letter to the member.
Outcome Of Contact	Other
Outcome Of Contact Other	Mailed the Post Opt-In Decline Letter to the member
Length Of Contact	15
Name of Provider	
Adult Day Healthcare	

Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 5/31/23, I mailed the Post Opt-In Decline Letter to the member. I spoke to the member yesterday, and he stated he no longer wants to be enrolled in ECM. I will proceed with disenrolling the member from ECM.

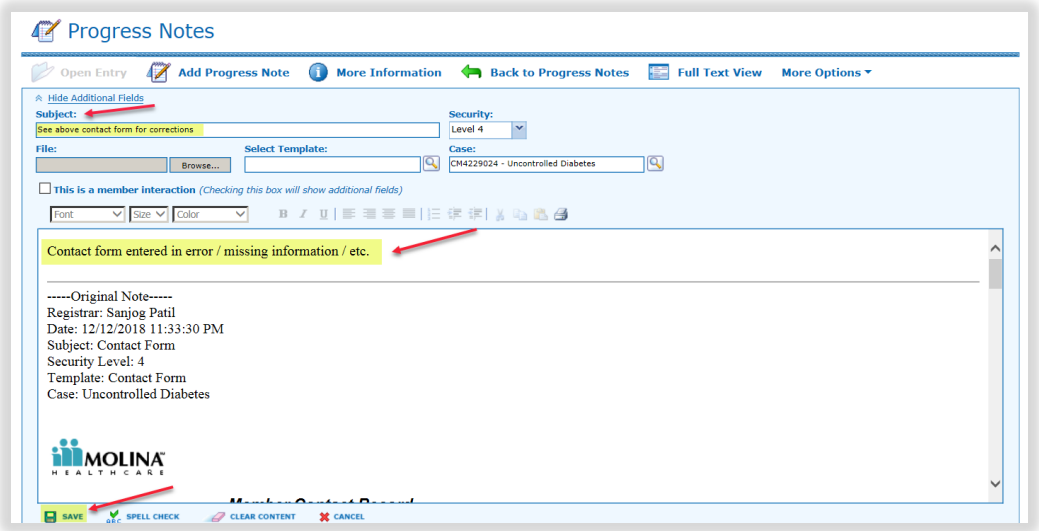
Appending Erroneous Contact Forms

Follow the steps below for appending erroneous contact forms:

INSTRUCTIONS	SCREENSHOT
Step 1: Highlight (click on the contact form to bring into focus) the erroneous contact form	
Step 2: Using the drop-down menu for **More Options**, select "Append."	
Step 3:	

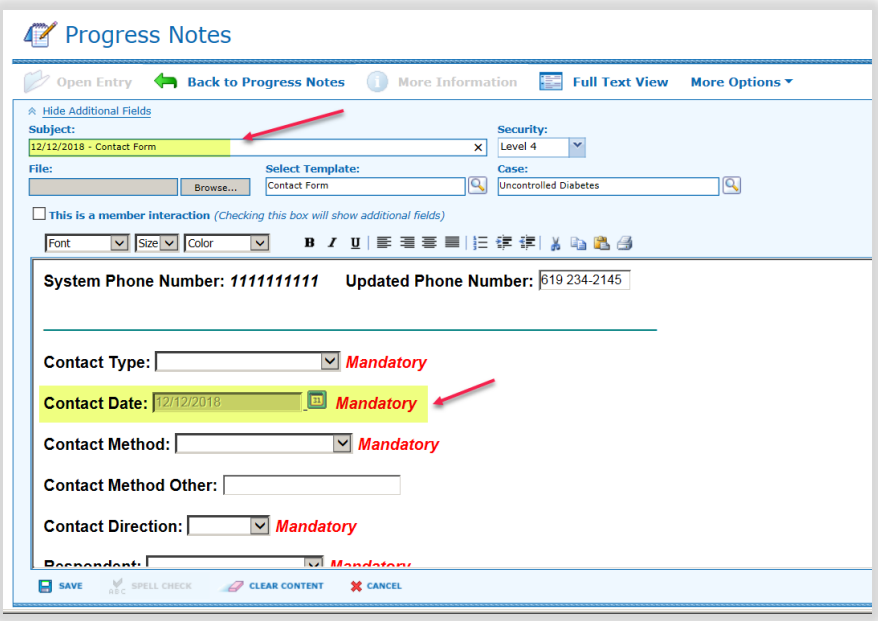
INSTRUCTIONS	SCREENSHOT

This will open a new progress form window, update the Subject line to “See above contact form for corrections,” and then indicate the reason for invalidating the current contact form in the body. Click “Save” to save changes.



Step 4

Create a new contact form following the standard, established process. Change the subject line to start with the date of the invalid contact form, and when selecting the date for the new contact form, be sure to use the date of the invalid form. Enter all other fields normally, and click save to finish the corrected form.



BH Crisis Line, Nurse Advise Line, & ED Encounters BH HEDIS FUM/FUA

Molina's ECM Team will notify the ECM Provider if any of their assigned enrolled members have called the BH Crisis Line or had an Emergency Department Visit for Mental Illness (FUM) and/or Alcohol and other drug abuse or dependence (FUA) recently, or called the Nurse Advise Line (NAL) and needs follow-up. For BH Crisis Line, follow-up needs to be done by the close of business from the date of notification. For members with Emergency Department Visit for Mental Illness (FUM) and/or Alcohol and other drug abuse or dependence (FUA), and for members who called the NAL, follow-up needs to be done within two business days from the date of notification. These follow-ups need to be documented via a contact form in CCA. Molina's BH Team will host a separate training to discuss BH Crisis; stay tuned.

Below are scenarios to consider when completing the Contact Form in CCA for BH Crisis Line, or Emergency Department Visit for Mental Illness (FUM) and/or Alcohol and other drug abuse or dependence (FUA), & Nurse Advise Line follow-up:

Scenario #1: Post-enrollment. Molina ECM Team informed the ECM Provider that the member called the BH Crisis Line. ECM Provider followed up with the member.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider BH Crisis Line Follow-up 4/27/23
Contact Type	General Contact
Contact Date	04/27/2023
Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM BH Crisis Call Follow Up
Purpose Of Contact Other	
Outcome Of Contact	Successful Contact
Outcome Of Contact Other	
Length Of Contact	30
Name of Provider	
Provider Contact Type	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/27/23, Molina ECM Team informed me that member called the BH Crisis Line. I called the member today. Member is seeking support and services due to substance use. I informed the member that I would submit a BH referral today.

Scenario #2: Post-enrollment. Molina ECM Team informed the ECM Provider that the member called the Nurse Advise Line. ECM Provider followed up with the member.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider NAL Follow-up 4/27/23
Contact Type	General Contact
Contact Date	04/27/2023
Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Follow-up Contact
Purpose Of Contact Other	
Outcome Of Contact	Successful Contact
Outcome Of Contact Other	
Length Of Contact	30
Provider Contact Type	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/27/23, Molina ECM Team informed me that member called the NAL. I called the member today. The member called the NAL because he noticed his sugar was too high (higher than other times) and was concerned. I informed the member that I would schedule a PCP appointment on his behalf; PCP might need to change his medications. I will also educate/coach the member on routinely checking his glucose and monitoring it so it does not get to 400, in addition to discussing his diet.

Scenario #3: Post-enrollment. Molina ECM Team informed the ECM Provider that the member called the BH Crisis Line. ECM Provider followed up with the member, and the member is UTC.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider BH Crisis Line Follow-up UTC #1 4/27/23
Contact Type	General Contact
Contact Date	04/27/2023

Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	N/A- UTC
Purpose Of Contact	ECM BH Crisis Call Follow Up
Purpose Of Contact Other	
Outcome Of Contact	Left Message
Outcome Of Contact Other	
Length Of Contact	1
Provider Contact Type	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/27/23, Molina ECM Team informed me that member called the BH Crisis Line. I called the member this morning, but the member didn't answer, so I left a message. I will call the member tomorrow evening.

Scenario #4: Post-enrollment. Molina ECM Team informed the ECM Provider that the member had an Emergency Department Visit for Mental Illness (FUM) and/or Alcohol and other drug abuse or dependence (FUA) recently. ECM Provider followed up with the member.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider ED Visit Follow-up 4/27/23
Contact Type	General Contact
Contact Date	04/27/2023
Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Follow Up
Purpose Of Contact Other	
Outcome Of Contact	Successful Contact

Outcome Of Contact Other	
Length Of Contact	30
Provider Contact Type	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/27/23, Molina ECM Team informed me that the member had an Emergency Department Visit for Mental Illness (FUM) and/or Alcohol and other drug abuse or dependence (FUA) recently. Member's diagnosis: suicidal; Suicidal ideation. I called the member this morning, who appears to be doing well. I confirmed member has an MH follow-up appointment with a provider on 5/1/23. I will continue monitoring the member and follow up with the member on 5/2/23 after the appointment.

ECM Enrollment Assessment

If an ECM Provider successfully contacts a member for enrollment into ECM, the ECM Provider must review ECM Program Eligibility and Populations of Focus with the member, and the member must verbally agree to data sharing to be enrolled in ECM.

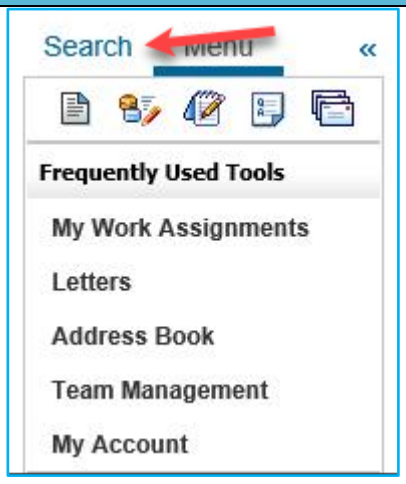
Regardless of the outcome of the outreach (member agrees to participate in ECM, member declines ECM, the member is in a duplicative program, the member does not meet any Population of Focus criteria, or the member is not enrolled (unable to contact), the ECM Provider is required to complete the Enrollment Assessment in CCA. If a member is UTC, the ECM Provider is required to complete the Enrollment Assessment after exhausting the minimum required attempts. Do not complete a disenrollment form if a member was never enrolled in ECM.

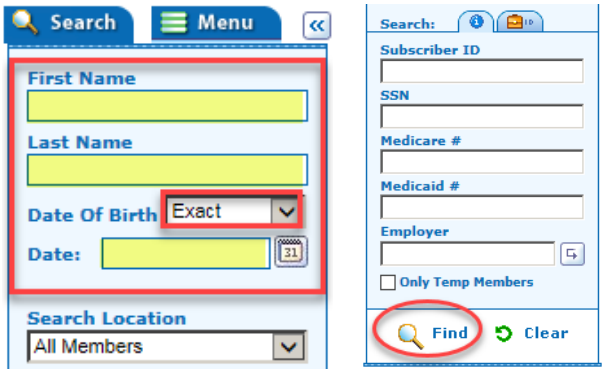
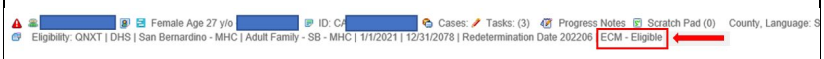
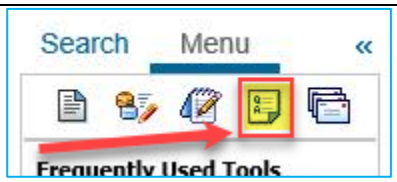
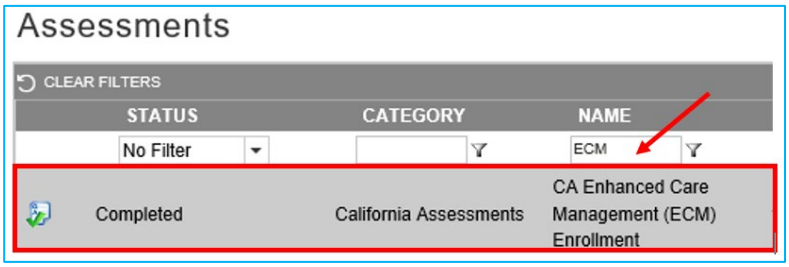
Members might not qualify for ECM due to being enrolled in a duplicative program. Such duplicative programs might include HIV/AIDS, Assisted Living Waiver, Developmentally Disabled, Multipurpose Senior Services Program, Home and Community-Based Alternatives, Self-Determination Program for Individuals with I/DD, California Community Transitions (CCT), Hospice, and Molina CM. Refer to the latest DHCS ECM Policy Guide for more information on exclusionary criteria.

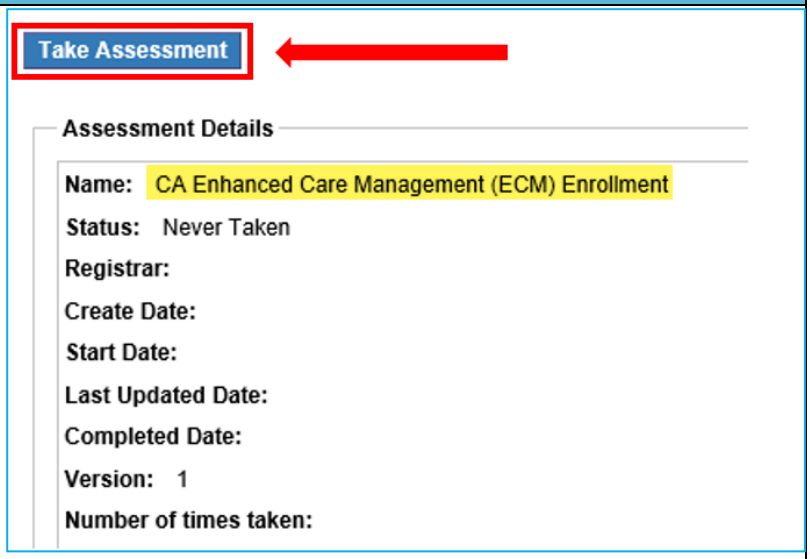
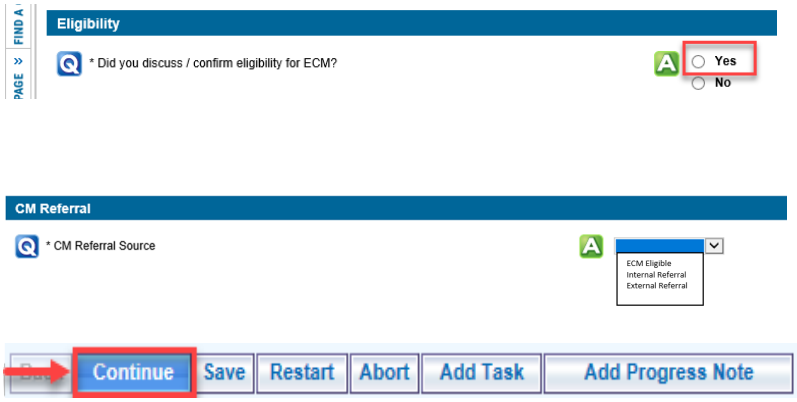
An ECM Enrollment Assessment is not required if a member is already enrolled in the ECM Program.

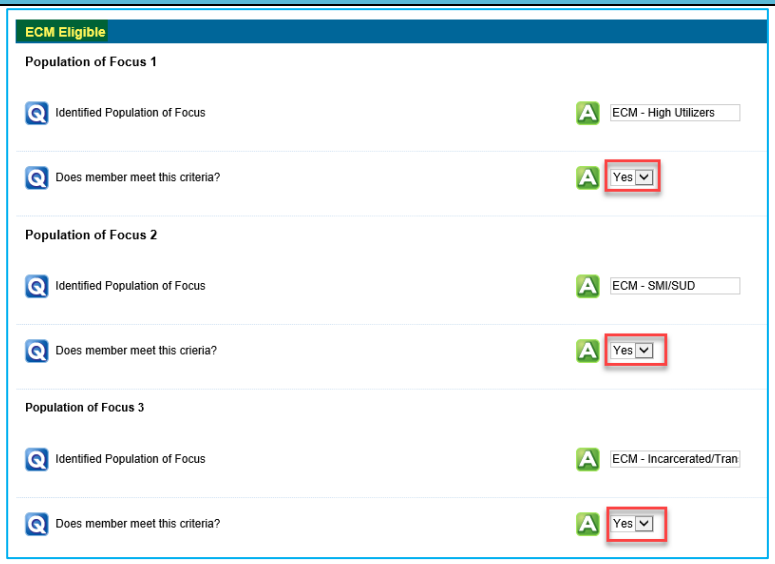
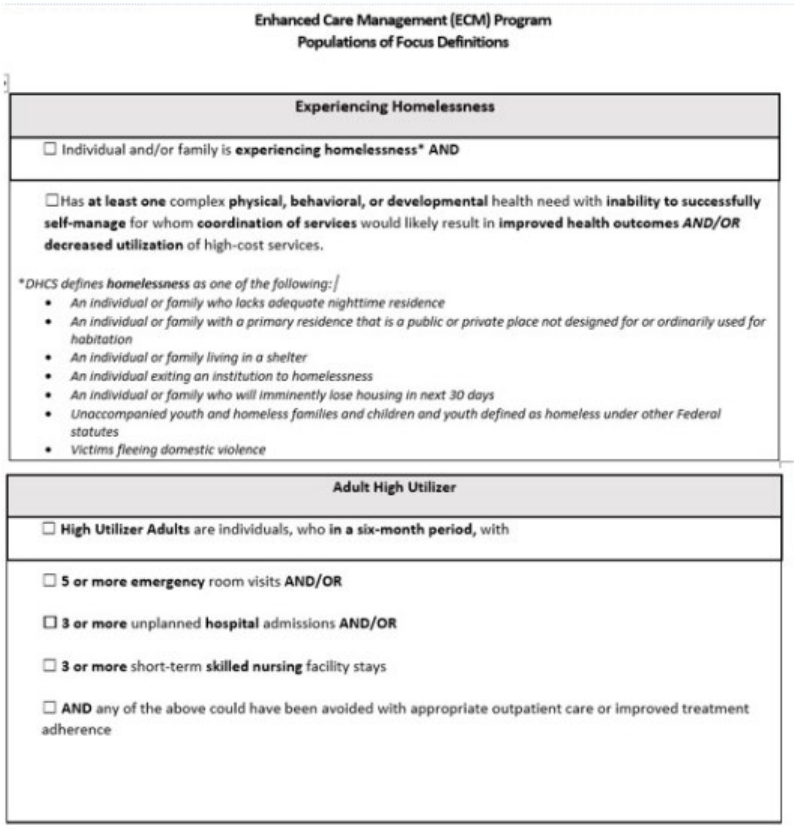
If you do not see a pre-identified Population of Focus in the ECM Enrollment Assessment, do not proceed with the assessment; notify Molina's ECM Team immediately. We'll need to troubleshoot the issue. If a member does not meet any pre-identified Population of Focus but meets another Population of Focus, please inform Molina's ECM Team so they can change their system. Complete the ECM Enrollment Assessment for the member after they've confirmed with you that they made this change.

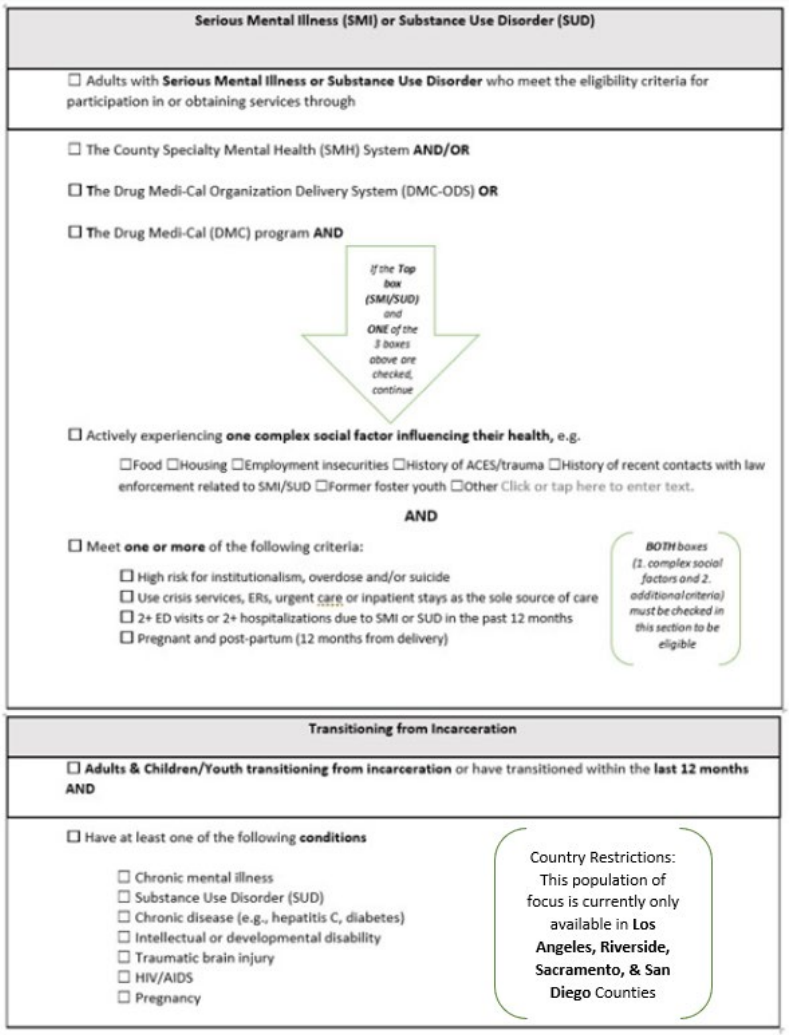
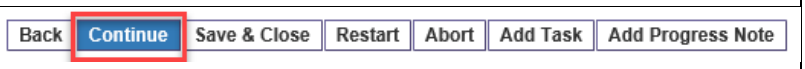
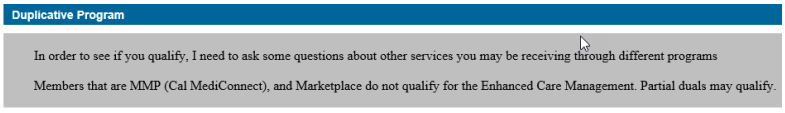
Successful Member Enrollment into ECM

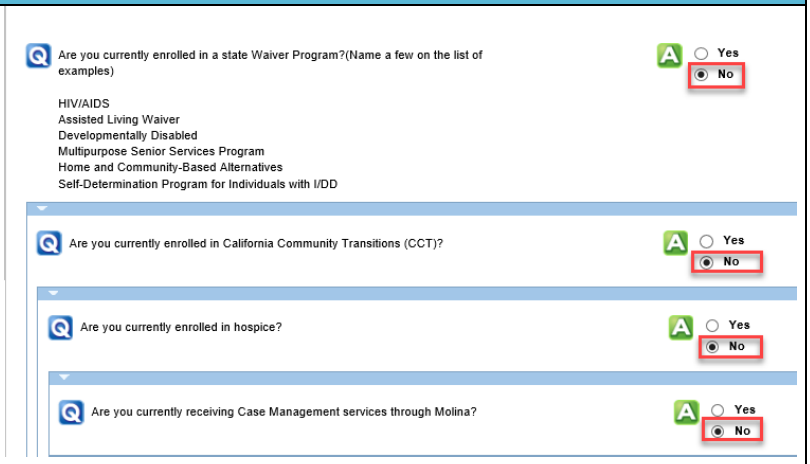
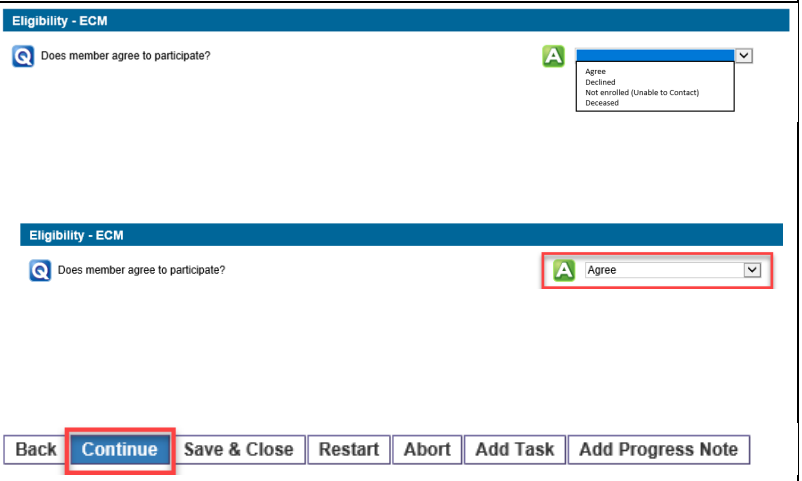
INSTRUCTIONS	SCREENSHOT
Access CCA and click on the **SEARCH** tab to enter the member's name	

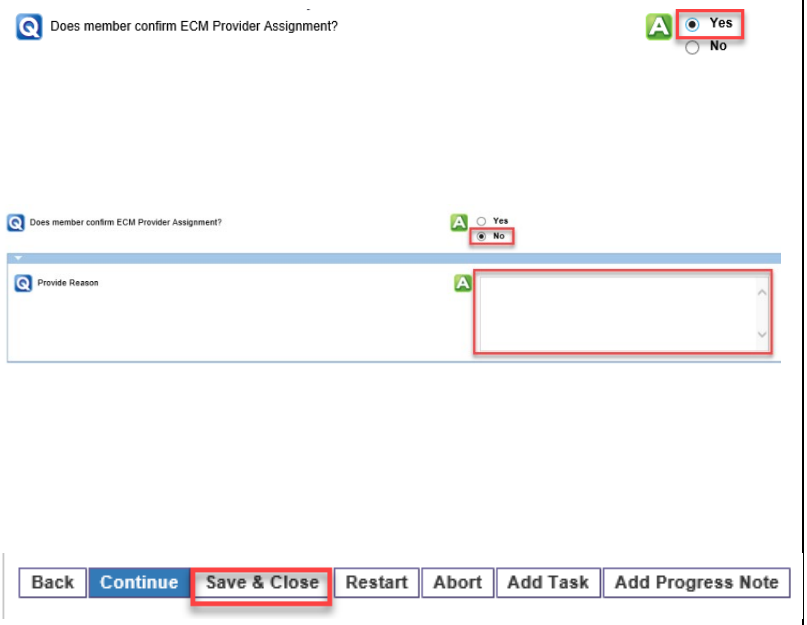
INSTRUCTIONS	SCREENSHOT
Type in the member's **FIRST NAME**, **LAST NAME**, and **DATE OF BIRTH** (selecting **EXACT** DOB from the drop-down box), then select **FIND** Alternate Search Criteria are available using the following: • Medicaid # • Employer = CA	
Search Results will populate members' information. Select the member by clicking on the member's name. This will bring the member "into focus."	
When the member is selected, Eligibility status will appear at the top banner of the **Search Results** screen: a. ECM Eligible ONLY ***No further enrollment actions are required if a member shows with ECM-Opt-In in the banner.***	
Select the **ASSESSMENTS** icon.	
Search for "ECM" in the "Name" field. Select **CA ENHANCED CARE MANAGEMENT (ECM) ENROLLMENT.**	

INSTRUCTIONS	SCREENSHOT
Select **TAKE ASSESSMENT**	
Answer A **MEMBER AND ECM INFORMATION** Q questions *Note: Some criteria will auto-populate*	
Q **DID YOU DISCUSS / CONFIRM ELIGIBILITY FOR ECM?** If A **YES**, select **ECM ELIGIBLE** *(for TEL members only)* from the drop-down in Q **CM REFERRAL SOURCE** and select **CONTINUE.** Molina's ECM Team will let you know which CM Referral Source to select if you enroll a referred member.	

INSTRUCTIONS	SCREENSHOT
This section is to assess if the member is ECM Eligible The Populations of Focus are automatically populated for ECM Eligible members (this should match what's in your organization's TEL): • ECM- Homeless • ECM- High Utilizers • ECM- SMI/SUD • ECM-Incarcerated/Transitioning to Community ***(ONLY for Los Angeles, Riverside, Sacramento, & San Diego counties)*** Confirm that the member meets the criteria for each Population of Focus by selecting Yes or No in question: Does the Member meet these criteria? The Populations of Focus definitions are found below the questions. We recommend always referring to the latest *CalAim Enhanced Care Management Policy Guide* from DHCS for these Populations of Focus to identify if the member meets the criteria.	 

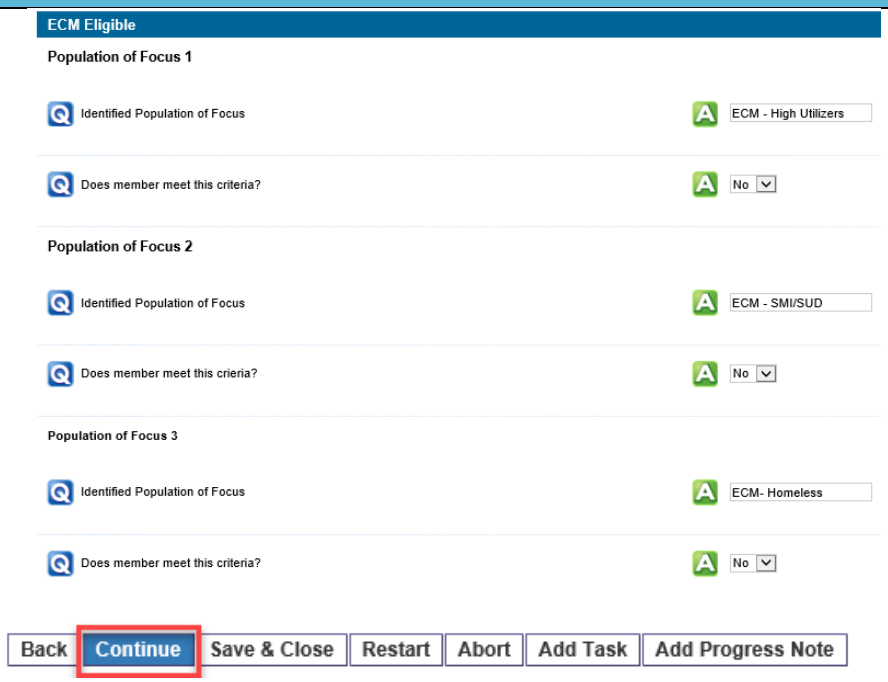
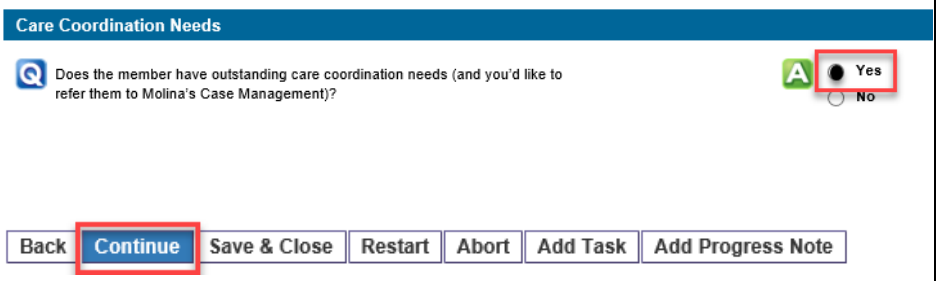
INSTRUCTIONS	SCREENSHOT
	
After answering A YES or NO to some questions in ECM Eligible section, select CONTINUE If A NO is answered for all criteria questions, see section: *Member Does not Meet Populations of Focus Criterion.*	
This section assesses if members are enrolled in a duplicative program that would exclude them from enrolling in the Enhanced Care Management Program.	

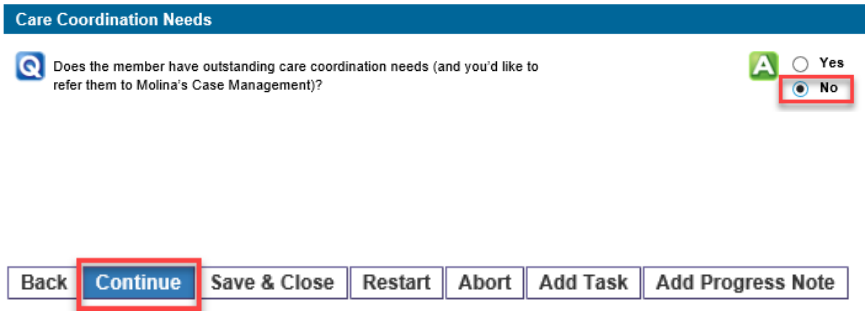
INSTRUCTIONS	SCREENSHOT
Ask the member the questions that appear in the window. If a member answers **NO** to all four questions, the member qualifies for the ECM Program. If a member answers **YES** to any of these questions, see the section: **"Yes" to Duplicative Program Questions.**	
DOES THE MEMBER AGREE TO PARTICIPATE? If **AGREE** is selected from the drop-down menu, click **CONTINUE.**	
THE ECM PROVIDER ASSIGNMENT screen will auto-populate the ECM Provider name with additional questions	

INSTRUCTIONS	SCREENSHOT
If YES to DOES MEMBER CONFIRM ECM PROVIDER ASSIGNMENT? Please confirm if the member agrees to have your organization as their assigned ECM Provider. If member would like to be assigned a different ECM Provider, please document the reason why and select **Save & Close**.	
• **Does the member provide a verbal agreement for data sharing related to care coordination through ECM?** Select **YES**, and select **Continue.** Since the member agreed to participate in the program, they consent to this question. Explain to the member that to provide ECM services; you will need to talk to their PCP & anyone else in their care team.	
• DESCRIBE CONTACT INFORMATION Provide contact phone numbers location/residence; best place to meet; places that the member frequents; the best time of day to call; the best time of day to meet; any consistent schedule that the member has/keeps; recurring appointments; where they receive mail; If the contact information provided does not match system: • Ask the member to update their contact information with their Medi-Cal Caseworker	

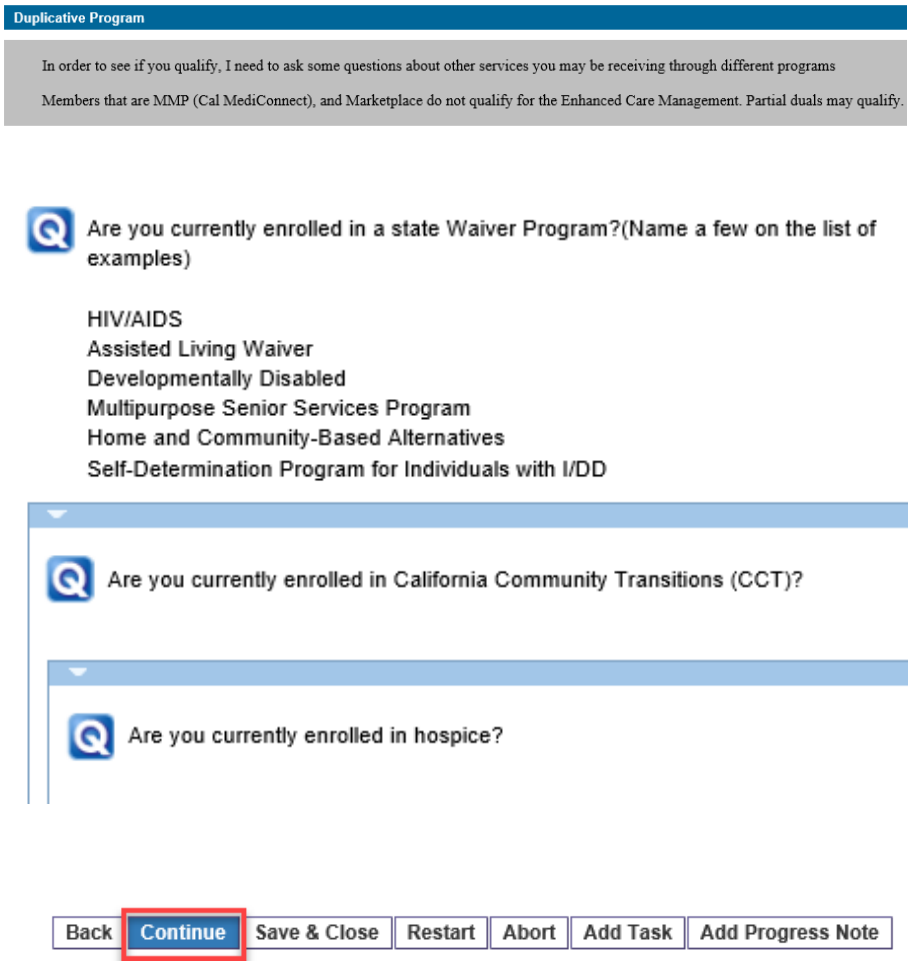
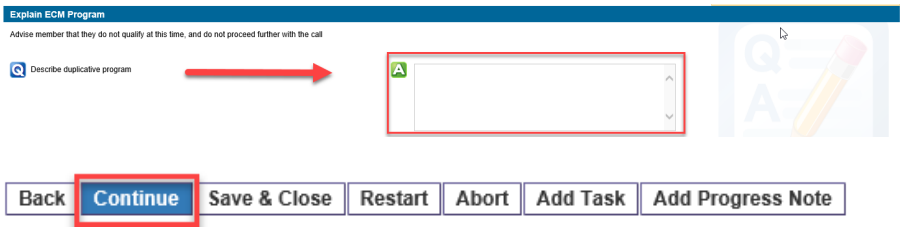
INSTRUCTIONS	SCREENSHOT
• Add this information to the Address Book • Or contact Molina's Member Services so they may update this in our system	
THE FINAL PAGE will appear indicating you have completed the Health Risk Assessment; this means you have now completed the **Enrollment Assessment,** and the member has been opted-in to ECM!	

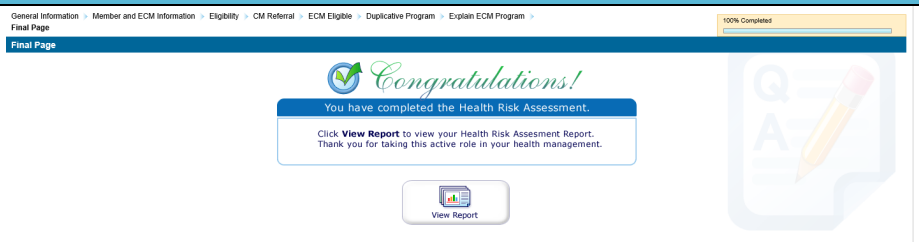
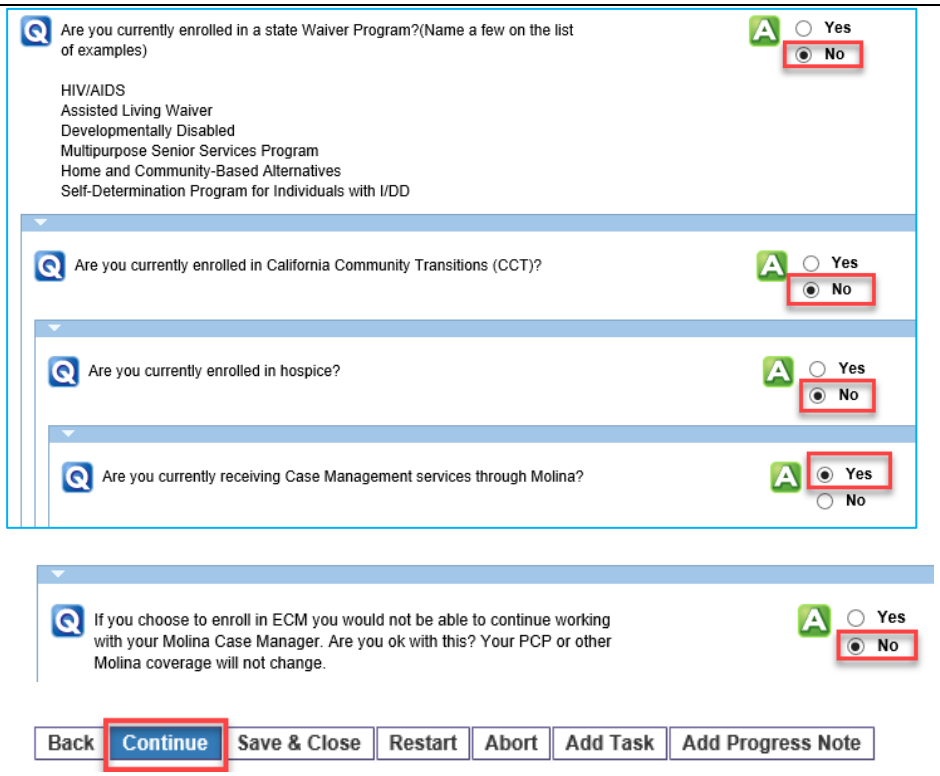
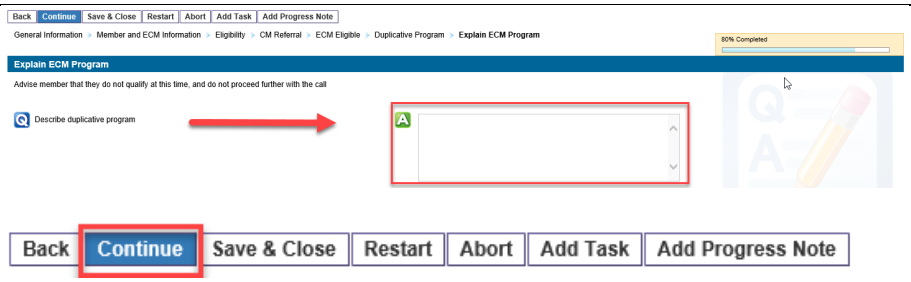
Member Does not Meet Populations of Focus Criterion

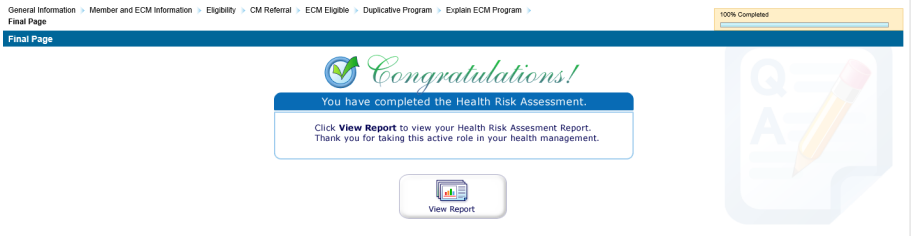
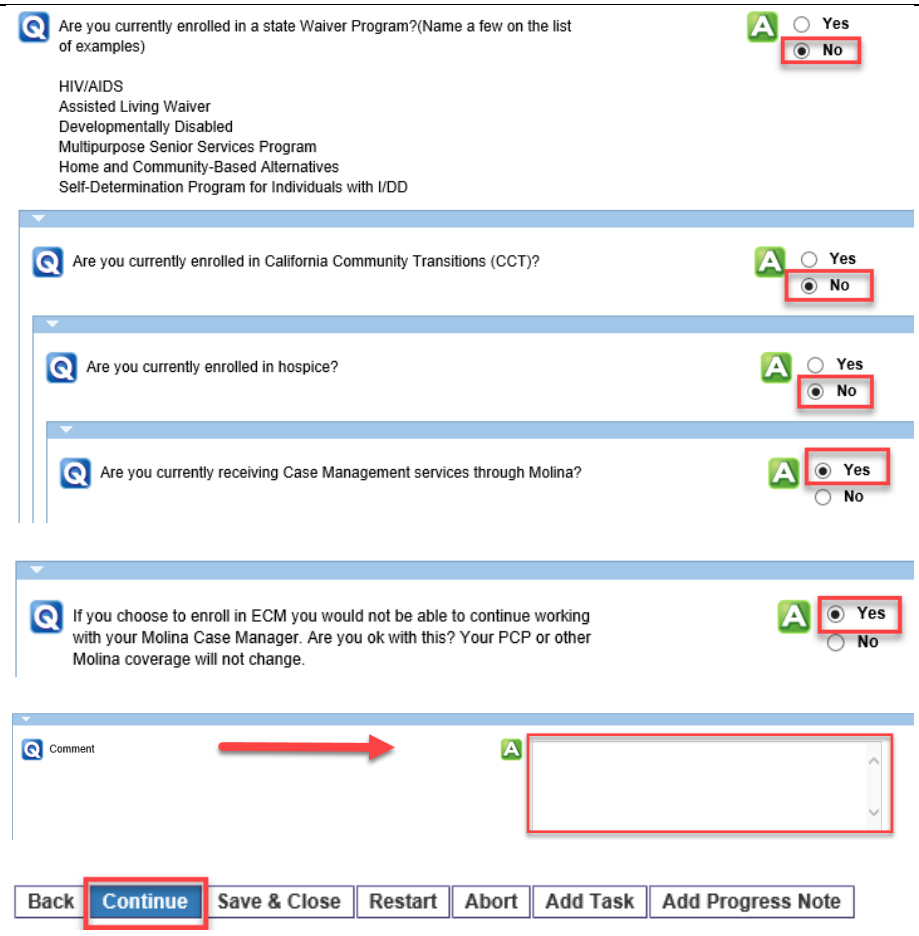
INSTRUCTIONS	SCREENSHOT
If **NO** is answered in all the questions: **DOES MEMBER MEET THESE CRITERIA?** select **CONTINUE**	
• **DOES THE MEMBER HAVE OUTSTANDING CARE COORDINATION NEEDS (AND YOU'D LIKE TO REFER THEM TO MOLINA'S CASE MANAGEMENT)?** If **YES**, select **CONTINUE** The member will be referred to Molina's Case Management Team. Advise the member that they do not currently qualify for ECM but may qualify for Molina's Case Management Program and will be contacted by a Molina representative. Thank the member and end the call. **FINAL PAGE** will appear indicating you have	 

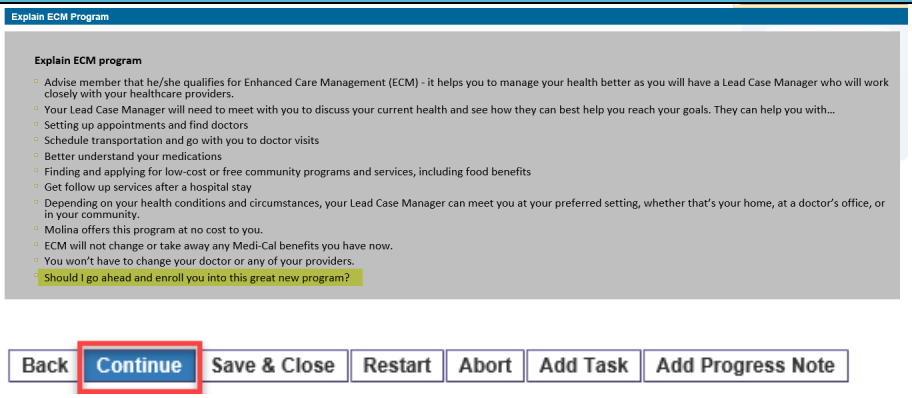
INSTRUCTIONS	SCREENSHOT
completed the Health Risk Assessment; this means you have now completed the **Enrollment Assessment**; however, since the member does not qualify for ECM, the member was not enrolled in the program.	
If member answers **NO** to question **DOES THE MEMBER HAVE OUTSTANDING CARE COORDINATION NEEDS (AND YOU'D LIKE TO REFER THEM TO MOLINA'S CASE MANAGEMENT)?** select **CONTINUE** Advise member that they do not currently qualify for ECM, thank the member, and end the call. **FINAL PAGE** will appear indicating you have completed the Health Risk Assessment; this means you have now completed the **Enrollment Assessment**; however, since the member does not qualify for ECM, the member was not enrolled in the program.	 

"Yes" to Duplicative Program Questions

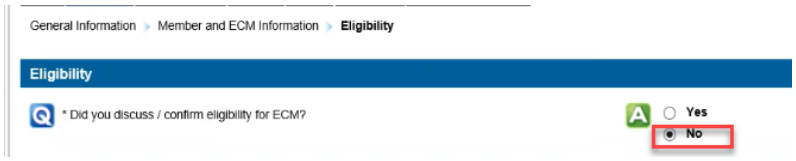
INSTRUCTIONS	SCREENSHOT
If **YES** is answered to any of the questions displayed, select **CONTINUE.**	
"EXPLAIN ECM PROGRAM" screen will appear – ADVISE MEMBER THAT THEY DO NOT QUALIFY AT THIS TIME, AND DO NOT PROCEED FURTHER WITH THE CALL, comments section will prompt to describe the duplicative program, enter this information, and select **CONTINUE.**	

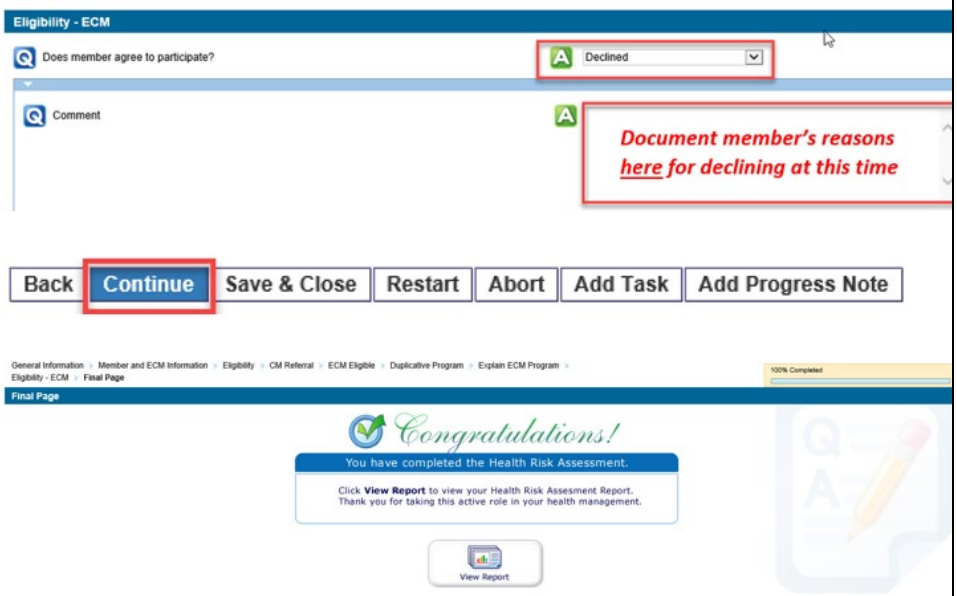
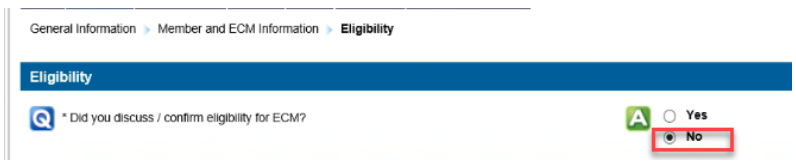
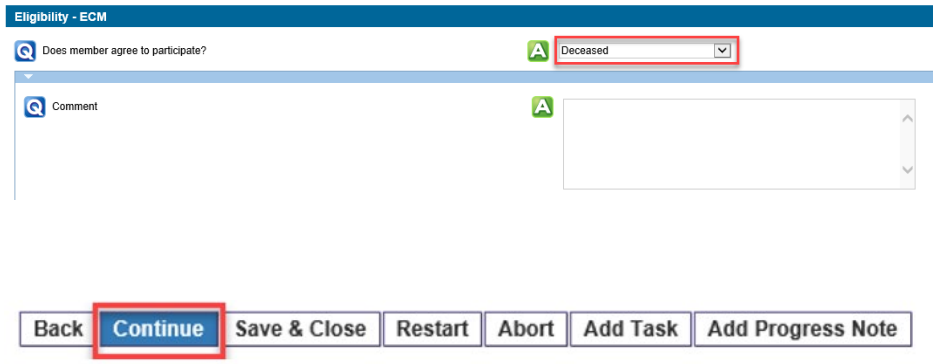
INSTRUCTIONS	SCREENSHOT
FINAL PAGE will appear you have completed the **Enrollment Assessment**; however, since the member does not qualify for ECM, the member was not enrolled in the program.	
If **NO** is answered to the three questions in the **DUPLICATIVE PROGRAM** section, the screen will appear – **ARE YOU CURRENTLY RECEIVING CASE MANAGEMENT SERVICES THROUGH MOLINA?** If **YES** is answered to the question, **IF YOU CHOOSE TO ENROLL IN ECM, YOU WOULD NOT BE ABLE TO CONTINUE WORKING WITH YOUR MOLINA CASE MANAGER. ARE YOU OK WITH THIS? YOUR PCP OR OTHER MOLINA COVERAGE WILL NOT CHANGE.** If **NO** comments section will prompt for completion and select **CONTINUE.**	
ADVISE MEMBER THAT THEY DO NOT QUALIFY AT THIS TIME AND DO NOT PROCEED FURTHER WITH THE CALL; comments section will prompt you to describe the duplicative program, enter this information, and select **CONTINUE.**	

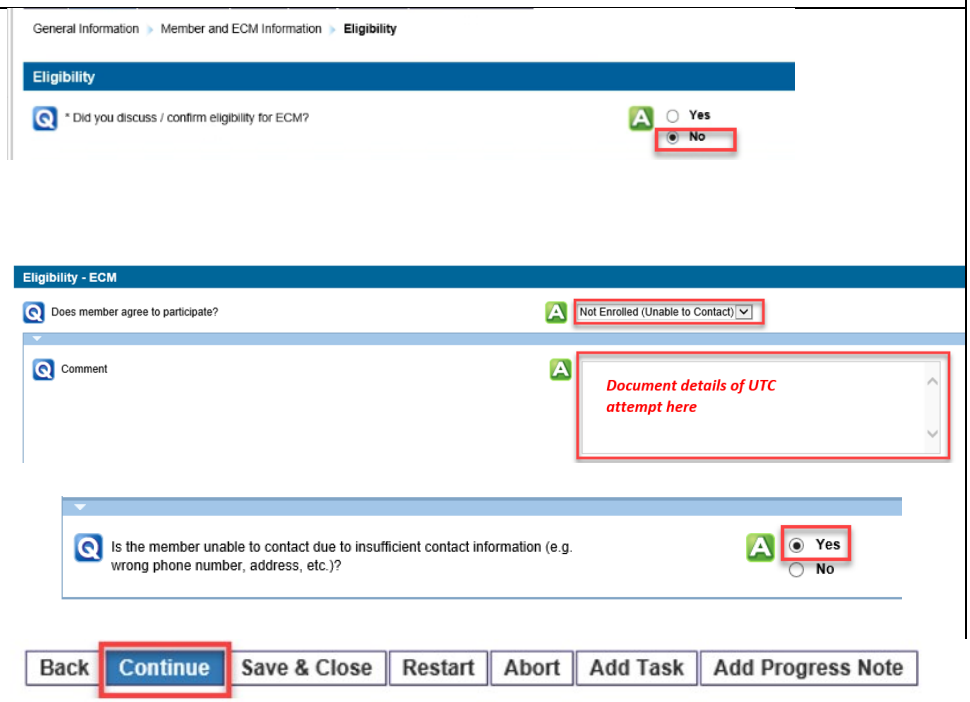
INSTRUCTIONS	SCREENSHOT
When the **FINAL PAGE** appears, you have completed the **Enrollment Assessment**; however, since the member wants to continue with Molina's Case Management, the member does not qualify for ECM and is not enrolled in the ECM program.	
If **NO** is answered to the three questions in the **DUPLICATIVE PROGRAM** section, the screen will appear – **ARE YOU CURRENTLY RECEIVING CASE MANAGEMENT SERVICES THROUGH MOLINA?** If **YES** is answered to the question, **IF YOU CHOOSE TO ENROLL IN ECM, YOU WOULD NOT BE ABLE TO CONTINUE WORKING WITH YOUR MOLINA CASE MANAGER. ARE YOU OK WITH THIS? YOUR PCP OR OTHER MOLINA COVERAGE WILL NOT CHANGE.** If **YES**, the comments section will be prompted; enter comments, and click **CONTINUE.**	

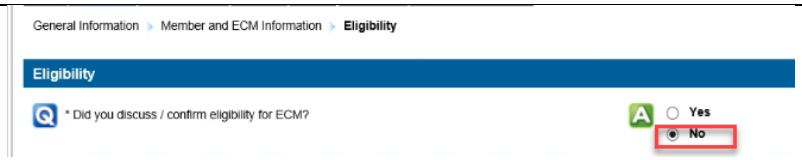
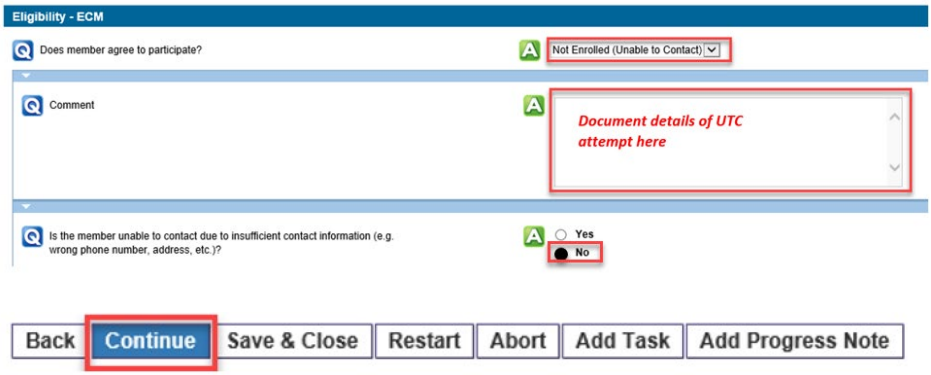
INSTRUCTIONS	SCREENSHOT
Explain the ECM Program to the member and ask the member (talking points will appear) **SHOULD I GO AHEAD AND ENROLL YOU INTO THIS GREAT NEW PROGRAM?** Select **CONTINUE.** Proceed with completing the Eligibility-ECM section & the Provider Assignment section. (See *Successful Member Enrollment into ECM* steps above for more information on how to complete these sections).	

Member Declines, Deceased, or UTC

INSTRUCTIONS	SCREENSHOT
Scenario #1: *Member Declined to participate* • **Does the member agree to participate?** If **DECLINED** is selected from the drop-down Menu, the comments section will prompt, enter comments ***(document member's reasons here for declining at this time)***, and click **CONTINUE.** The **FINAL PAGE** will appear, indicating you have completed	

INSTRUCTIONS	SCREENSHOT
the Health Risk Assessment. You have now completed the **Enrollment Assessment.** The member was not enrolled in the ECM Program.	
Scenario #2: *Deceased Member* • **Does the member agree to participate?** Documentation is not required if Deceased is selected from the drop-down Menu. Click **CONTINUE.** The **FINAL PAGE** will appear, indicating you have completed the Health Risk Assessment. You have now completed the **Enrollment Assessment.** The	 

INSTRUCTIONS	SCREENSHOT
member was not enrolled in the ECM Program.	
Scenario #3: *Member UTC due to insufficient contact information* • **Does the member agree to participate?** If you are unable to contact the member due to insufficient contact information (e.g., wrong address, phone number, etc.), select **Not Enrolled – UTC**, document details of the UTC attempt, and answer **YES** to the question, ***"Is the member unable to contact due to insufficient contact information."*** Select **CONTINUE.** The **FINAL PAGE** will appear, indicating you have completed the Health Risk Assessment. You have now completed the **Enrollment Assessment.** The member was not enrolled in the ECM Program. *Note: This member will be routed to the Member Location Unit at Molina for assistance finding alternate contact information. Be on the lookout for tasks from the Member Location Unit within two business days.*	 

INSTRUCTIONS	SCREENSHOT
If provided with alternate contact information and were successful in getting a hold of the member, please retake the **Enrollment Assessment.**	
Scenario #4: *Member UTC after four non-mail attempts & UTC Letter sent* • **Does the member agree to participate?** If the member has been outreached four times (such as in-person meetings where the member lives, seeks care, or is accessible; email, telephone; community and street-level outreach) and a UTC letter has been sent (refer *to Generating Letters and ECM Care Plan Report QRG for steps*) for a **total of five attempts**, complete the **Enrollment Assessment** and select **Not Enrolled – UTC** for the question "**Does the member agree to participate**," document details of UTC attempts, and select **NO** for the question **"Is the member unable to contact due to insufficient contact information."** Select **CONTINUE.** The **FINAL PAGE** will appear, indicating you have completed the Health Risk Assessment. You have now completed the **Enrollment Assessment.** The member was not enrolled in the ECM Program.	  

ECM Provider Sample Telephone Outreach Script

Hi, this is [CALLER NAME] with [ORGANIZATION NAME] here in [COUNTY OR TOWN]. Am I speaking with [MEMBER NAME]? *(verify demographics here)*

I am calling because you have qualified to now receive a free additional program as a part of your Medicaid health insurance through Molina Healthcare. I'd like to share more about this program with you.

The program I am calling about is Enhanced Care Management. The program helps you to manage your health better as our care coordinator will work closely with your healthcare providers.

We can help with:

- Referral to community support services, such as housing tenancy & sustaining services.
- Find and apply for low-cost or free community programs and services, including food benefits.
- Set up appointments and find doctors
- Schedule transportation and go with you to doctor visits
- Better understand your medications
- Get follow-up services after a hospital stay

Depending on your health conditions and circumstances, we can meet you at your preferred setting, home, doctor's office, or community. This is what makes Enhanced Care Management different from other programs.

Would you like me to schedule a meeting so I can tell you more about the program?

Are there days or times that work better for you? *(Offer an appointment day and time.)* This is the address I have for you [MEMBER ADDRESS].

Would you like me to meet you at this address?

Are there any other phone numbers I can reach you at?

Is there someone else, like a family member, which you would like to be at the visit?

Do I have your permission to contact them? May I have their contact information?

Thanks for your time today. I look forward to meeting you on [DAY] at [TIME].

If something comes up and you need to reschedule, you can reach me at [CALLER PHONE NUMBER]. My name is [CALLER NAME]. I can wait if you want to write this information down.

Thank you for scheduling a visit. Do you have any questions I can answer now?

Letter Templates

ECM LCMs are required to mail our state-approved letters to our members and members' PCP (ECM Care Plan Letter). ECM LCMs must make every attempt to mail the letter to the member and the member's PCP. ECM LCM needs to document via a contact form when a letter has been mailed and when they are unable to mail a letter (specific letter template in the subject line and notes section).

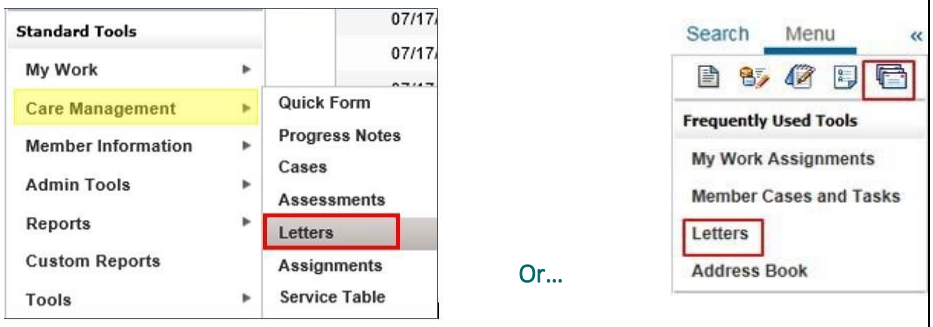
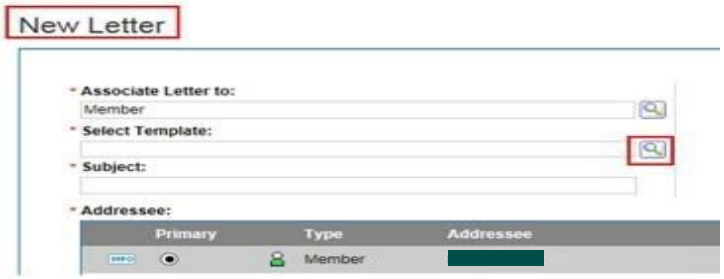
Below is a complete list of Molina's ECM letter templates:

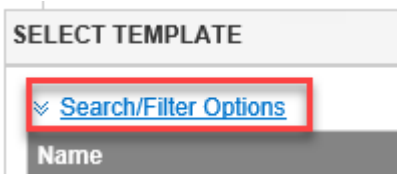
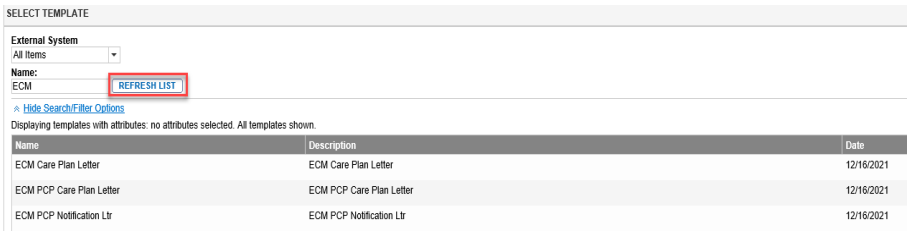
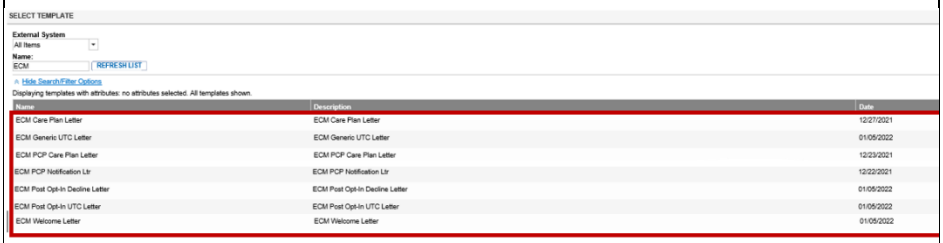
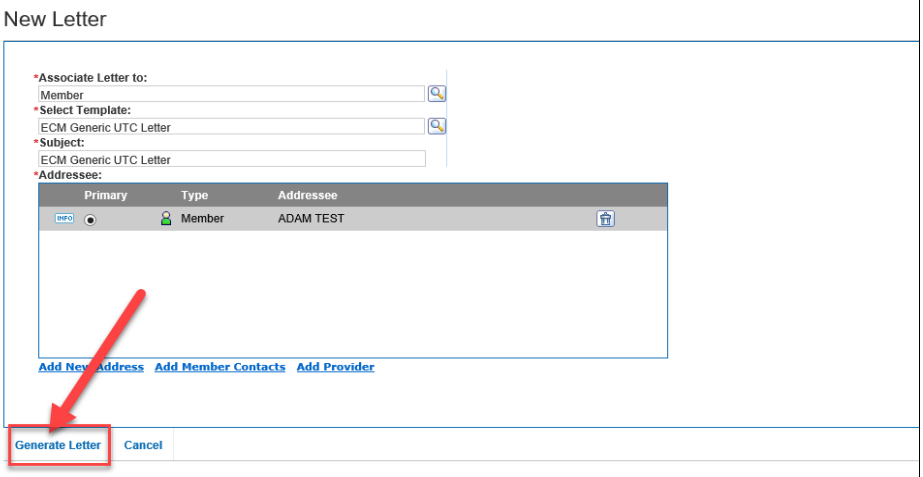
Letter Template	Usage
ECM Generic UTC Letter	To be mailed when a **TEL member** is unable to be contacted (UTC). The 5th attempt. *Do not mail this letter to a member who is already enrolled in ECM.*
ECM Welcome Letter	To be mailed to **newly enrolled** members. If the member meets program requirements and agrees to enroll in ECM, the ECM Welcome Letter is timely sent to the member *within three business days* from ECM Opt-In. *Do not mail this letter to a member not enrolled in ECM.*
ECM Care Plan Letter (initial and updates)	To be mailed to an **enrolled member** upon creating the member's Care Plan and changes to the Care Plan Goals. Mail this letter to the member after creating the care plan (Best Practice: within three business days from completion of the care plan, no later than 90 days from ECM Opt-In) along with a copy of the care plan. For care plan updates, mail this letter and a copy of the care plan to the member. *Do not mail this letter to a member not enrolled in ECM.*
ECM PCP Care Plan Letter	To be mailed to the **enrolled member's PCP** upon creating the member's Care Plan and upon changes to the Care Plan Goals. Mail this letter to the member's PCP after completing the care plan (no later than 90 days from ECM Opt-In) along with a copy of the care plan. For care plan updates, mail this letter and a copy of the care plan. *Do not mail this letter if the member has not enrolled in ECM.*
ECM Post Opt-In UTC Letter	To be mailed to an **enrolled member** who is unable to be reached following the UTC process. The 4th attempt. *Do not mail this letter to a member not enrolled in ECM.*
ECM Post Opt-In Decline Letter	To be mailed to an **enrolled member** when the member declines further participation in the program. *Do not mail this letter to a member not enrolled in ECM.*
ECM PCP Notification Letter	FYI Only: Molina automatically generates and mails this letter to a newly enrolled member's PCP if the PCP is listed in Molina's system.
ECM PHQ-9 PCP Notification Letter	To be mailed to **enrolled member's PCP** upon completion of the Patient Health Questionnaire 9 (PHQ9). **This letter is unavailable in CCA; Molina ECM Team has provided the template.**
PC-PTSD 5 PCP Letter	To be mailed to **enrolled member's PCP** upon completion of the Primary Care Post Traumatic Stress Disorder-5 (PC PTSD-5). **This letter is not available in CCA; Molina ECM Team has provided the template.**

If you need any of these letters in another language, please notify Molina's ECM Team: MHC_ECM@MolinaHealthCare.Com

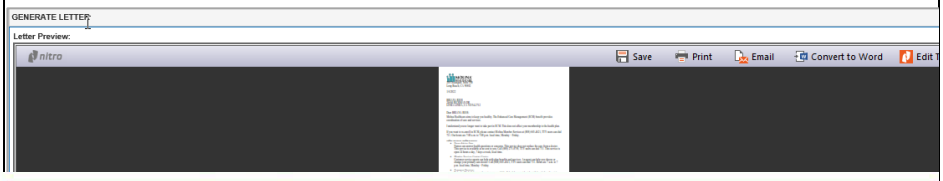
Generating Letters in CCA and Attaching ECM Care Plan Letter to the ECM Care Plan

The steps below demonstrate how to generate letters in CCA and attach the ECM Care Plan to the Care Plan Letters.

INSTRUCTIONS	SCREENSHOT
Step 1: With the Member in Focus, go to the [**Letters**] Module in CCA.	
Step 2: Click on [**New Letter**] on Top Banner.	
Step 3: To the right of the ***Select Template** field, click on the magnifying glass to search for the desired letter template. Below is a list of all our ECM Letter Templates found in CCA: • ECM Generic UTC Letter • ECM Welcome Letter • ECM Care Plan Letter (initial and updates) • ECM PCP Care Plan Letter • ECM Post Opt-In UTC Letter • ECM Post Opt-In Decline Letter	

Step 4: Click on the **Search/Filter Options** to expand. In the **Name** field, enter the Letter Name *(Full or partial name can be used).* Click [**Refresh List**]. Scroll to select the letter.	 
Step 5: Select the Letter (a gray highlight banner will mark the letter). After selecting the letter template, click [**Generate Letter**] on the bottom to generate a letter template for the member.	 

Step 6: Click [Edit Letter] in PDF Viewer to edit the letter.



Click [**Open**] on Pop-Up Banner at the bottom of the screen.

Only the Available options for the letter will light up.

In MS Word:

Click on [**Enable Editing**] in the yellow banner at the top.

Edit the carrot areas <XXXX> in the letter and any other areas as applicable.

First time editing a CCA letter in MS Word:

***NOTE:**

If this is the first time Editing a CCA letter in MS Word, you may be asked to [**Trust this add-in**]. This is the *communication link* from CCA, the CAE Letter Editor.

Click on [**Trust this add-in**].

For the following letters only, follow Steps 7-8. The process ends in Step 8:

- ECM Generic UTC Letter
- ECM Welcome Letter
- ECM Post Opt-In UTC Letter
- ECM Post Opt-In Decline Letter

Step 7: CAE Letter Editor

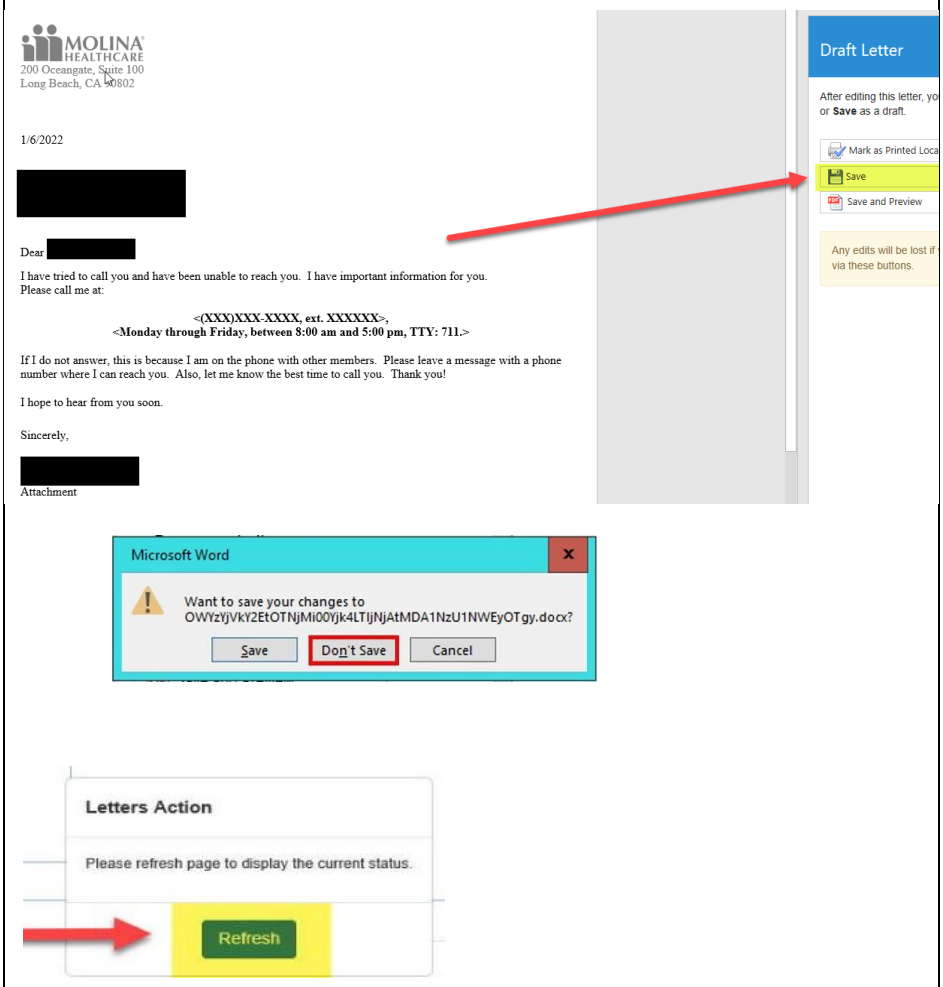
Do not close this window!

Once all edits to the letter are made, click on [**Save**].

Once the modifications have been saved, the following message will appear.

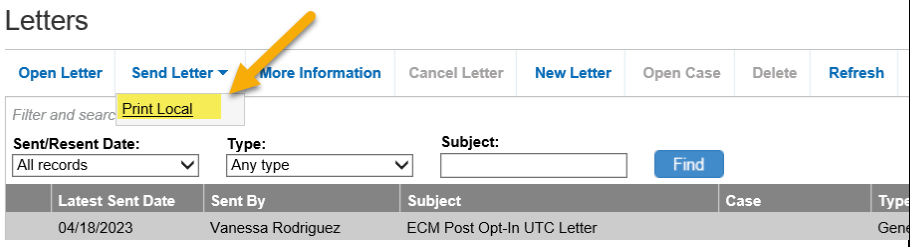
Exit out of MS Word; do *not* save the letter locally (to your computer).

Click on [**Refresh**] in CCA.



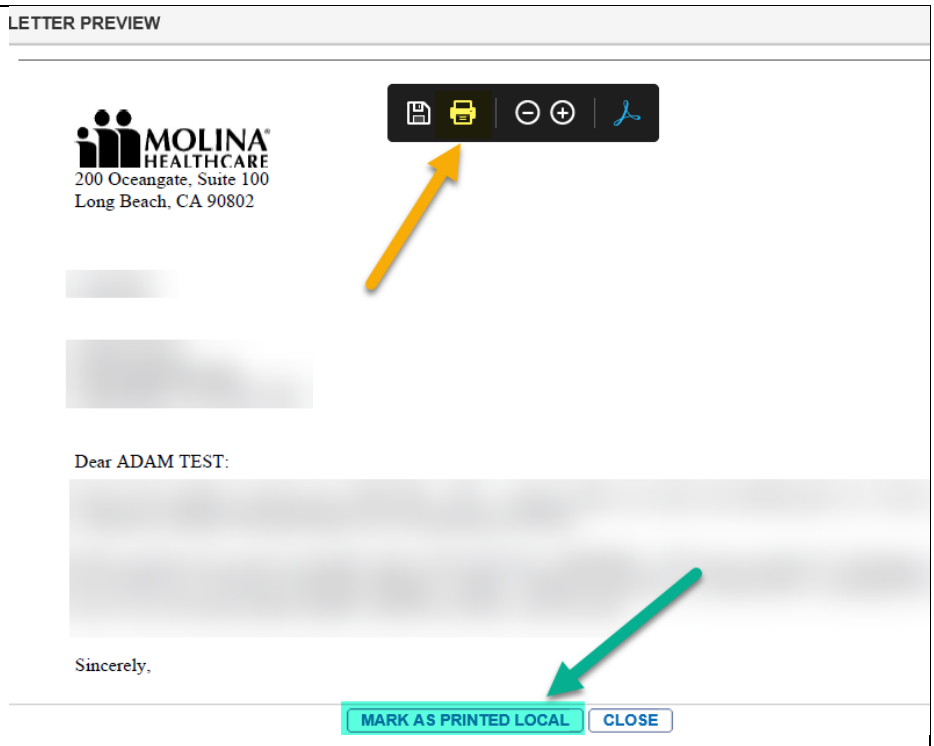
Step 8: Click on [**Print Local**] (under Send Letter)

The letter will preview. Click on the printer icon to print the letter. After the letter has been printed, click on **[MARK AS PRINTED LOCAL]**



The status will reflect **Sent.** **Congratulations, you've printed one of the following letters:**

- ECM Generic UTC Letter
- ECM Welcome Letter
- ECM Post Opt-In UTC Letter
- ECM Post Opt-In Decline Letter

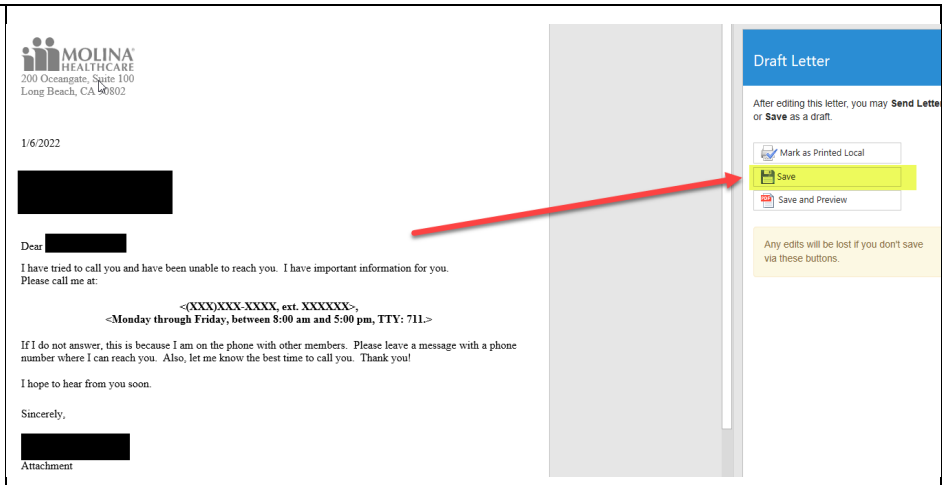


For the following letters only, follow Steps 9-13. The process ends at Step 13:

- ECM Care Plan Letter (initial and updates)
- ECM PCP Care Plan Letter

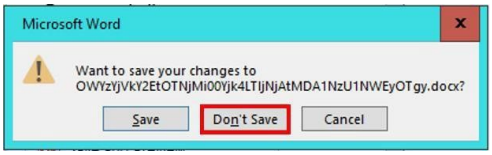
Step: CAE Letter Editor

Do not close this window!



Once all edits to the letter are made, click on [**Save**].
Do Not click Mark as Printed Local.

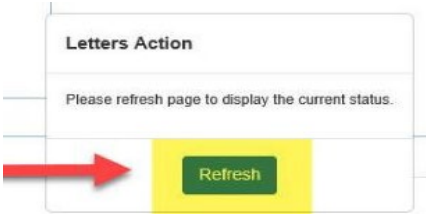
To attach documents in CCA, the letter needs to be a Draft.



Once the edits have been saved, the following message will appear.

Exit out of MS Word; do *not* save the letter locally (to your computer).

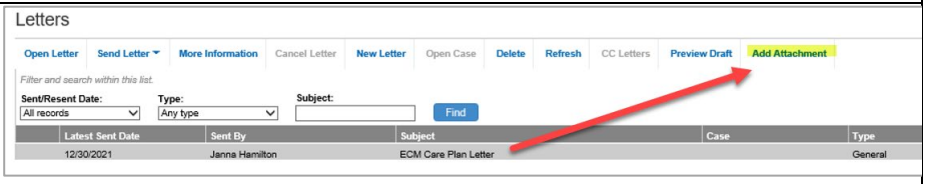
Click on [**Refresh**] in CCA.



Step 9: To attach ECM Care Plan to the letter:

- Select the Draft letter to highlight it.

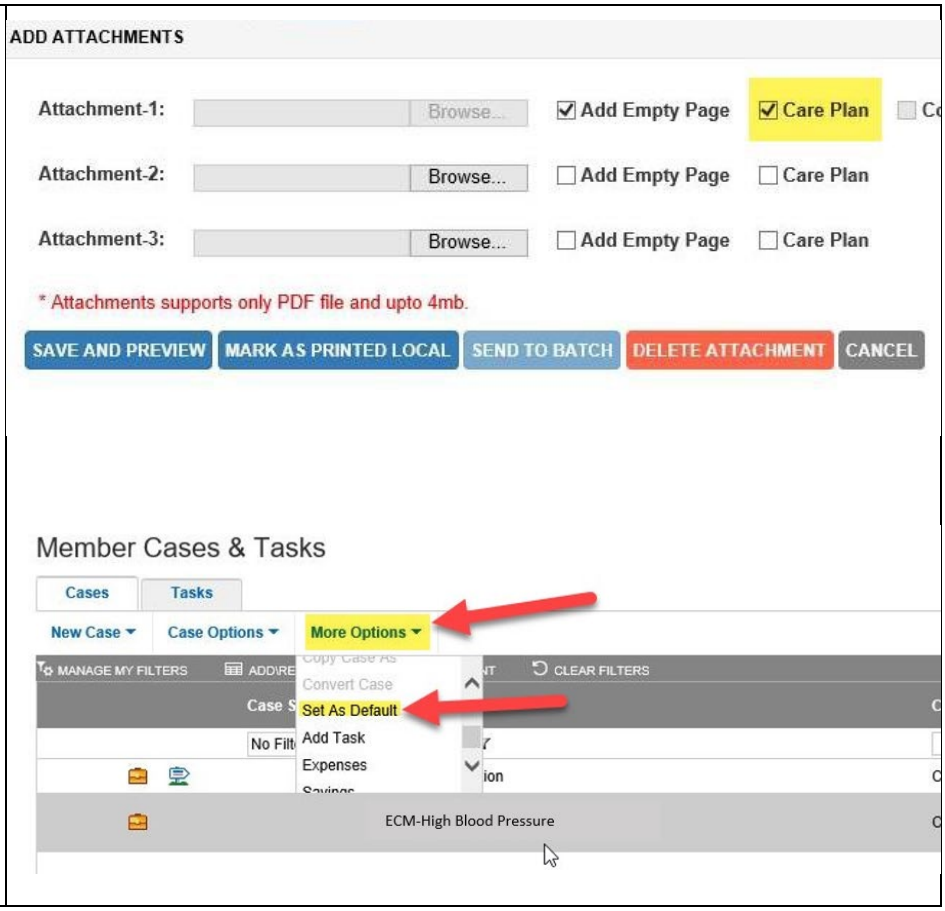
In the Top Banner Options, click [**Add Attachment**].

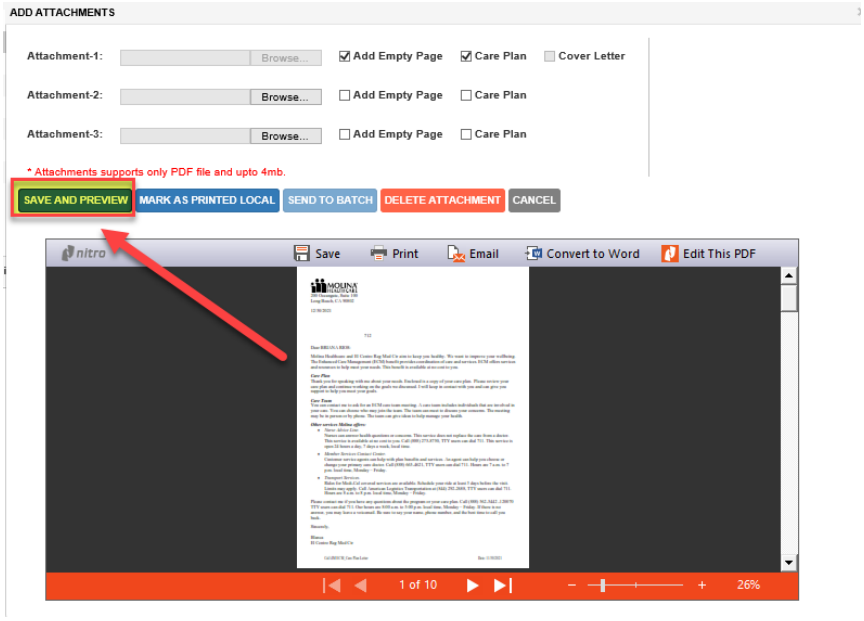
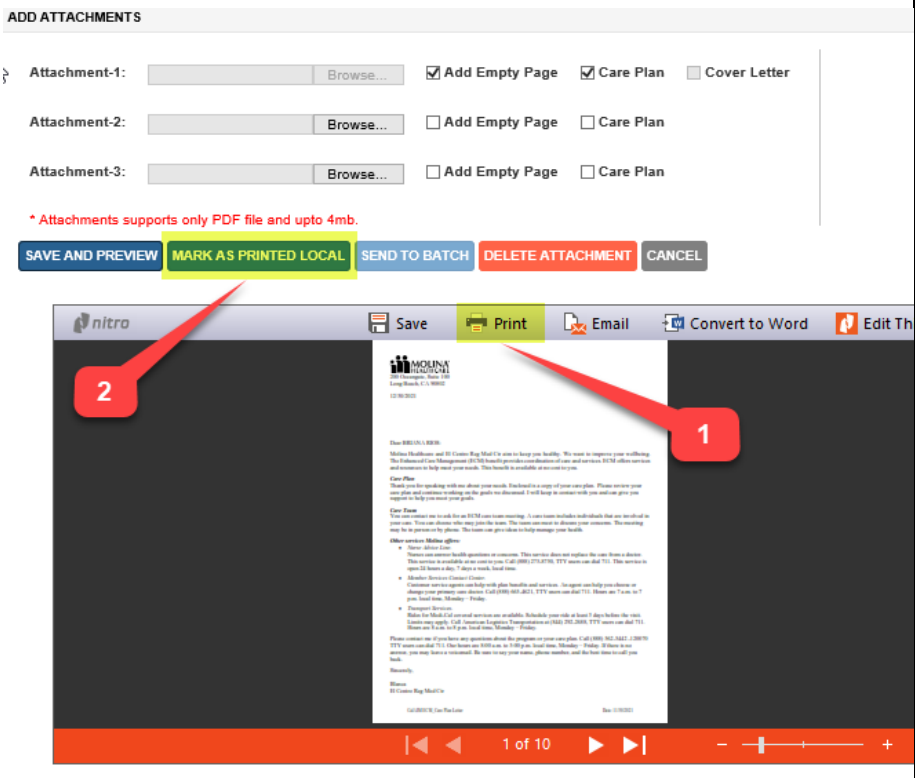


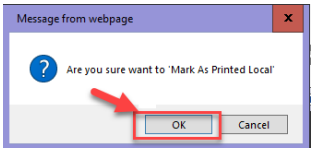
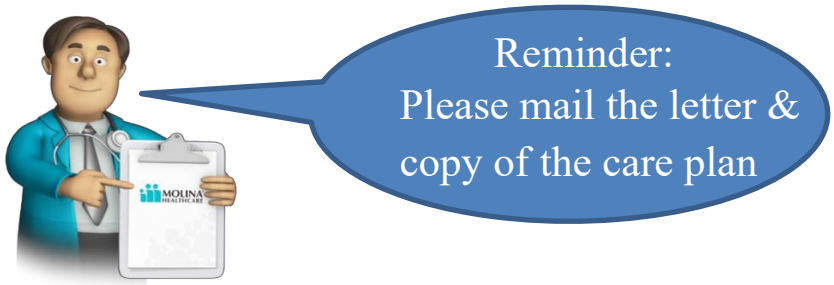
Step 10: To attach the ECM Care Plan, check "Add Empty Page" and "Care Plan." This will automatically add a blank page to ensure the care plan does not print on the back of the letter.

- **You will only be able to attach the ECM Care Plan using this method if the ECM Care Plan is the primary case in CCA's Cases Tab.**

To make the ECM case primary, highlight the ECM case, select [**More Options**] and click [**Set As Default**].



INSTRUCTIONS	SCREENSHOT
Step 11: Save and Preview your draft letter in the editor.	
Step 12: Select Print option: 1. Select the printer icon 2. Once document has printed, click [**Mark as Printed Local**] You will receive a prompt message asking if you want to mark the letter printed locally. Click [**OK**]. Click [**REFRESH**] when prompted. The letter should now reflect printed status.	

INSTRUCTIONS	SCREENSHOT
	 
Step 13: Congratulations, you have printed the ICP report and care plan letter! Keep in mind there are two care plan letters, and both need to be mailed: • ECM Care Plan Letter (initial and updates)- For the member • ECM PCP Care Plan Letter- For the member's PCP	

Health Risk Assessment

Molina's ECM Program members must complete an initial Health Risk Assessment (CA-HRA) to determine care coordination needs. The HRA is the primary tool used to create the ECM Care Plan. The CA-HRA should be completed upon ECM enrollment (no later than 90 days from the date of enrollment, Best Practice: within three business days of enrolling a member), every six (6) months after (known as the HRA Reassessment), and upon the change in member's condition or health status. Suppose an existing Medi-Cal member changes product lines and is designated "Seniors and Persons with Disabilities (SPD)." In that case, the CA-HRA must be completed within 30 days of the member's enrollment as SPD. Molina's ECM Team will notify your organization if this change occurs.

ECM Providers are required to document the completion of the CA-HRA, including all attempts made toward the completion of the HRA (whether they were successful or not) via a Contact Form in CCA. Refer to ***Contact Form & Attempts*** section above for more details and examples of documentation.

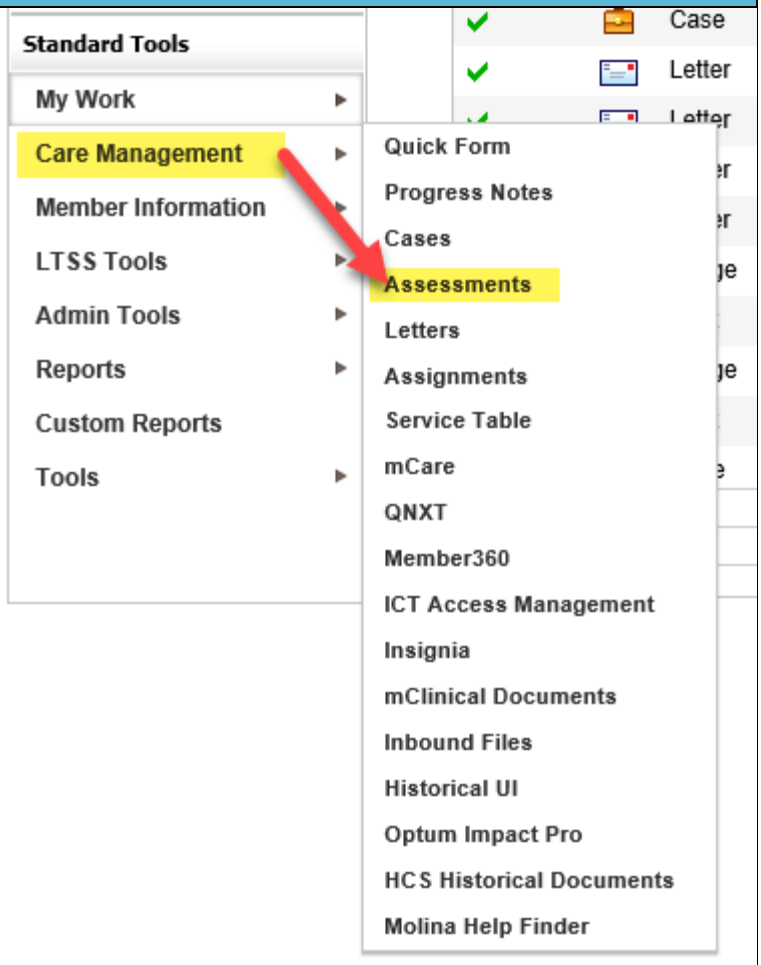
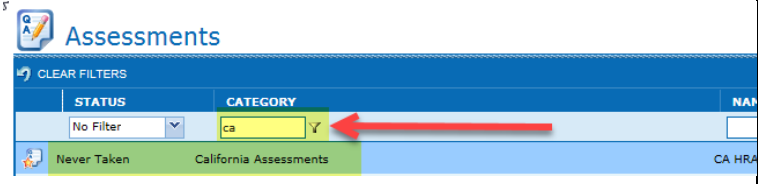
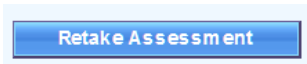
All sections within the CA-HRA must be completed; however, the reason should be indicated within the HRA if a section is not applicable. Sections that can be skipped include Broker Writing Number and Assessment Source. The CA-HRA has branching logic and follow-up questions that need to be answered. CA-HRA Question "Was the Pre-Call Review note completed?" correlates with the Pre-Call Review exercise all our ECM Providers must complete post-enrollment, and before working with the member; refer to the ***Pre-Call Review*** section above for more information.

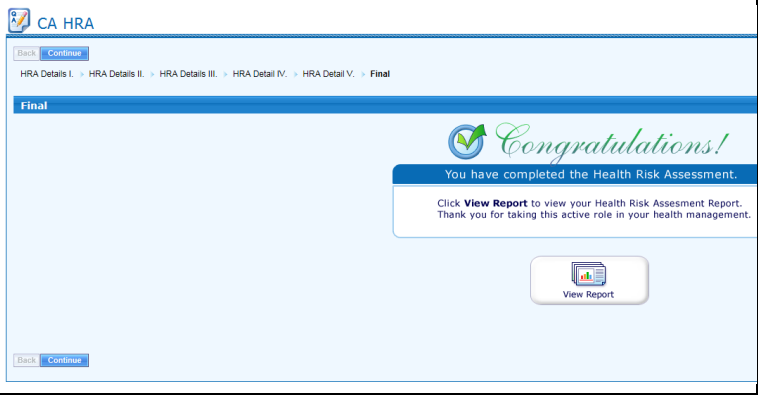
ECM Providers should target and narrow down to one or two health conditions as agreed upon with the member for CA-HRA Question, "What is your main health concern right now?"

Suppose the member answers "Request further information" on the CA-HRA question on Advance Directives. In that case, the system will automatically mail the Advance Directives booklet to the member to the address and language we have on record. However, if a member requests an Advance Directive booklet during the completion of the CA-HRA in a different language than what is showing in our system (e.g., the member's language shows as English, but it's Spanish) or if the member didn't receive the Advance Directive booklet, the ECM LCM is required to task Janna Hamilton and request she mails this information. If, upon completion of the CA-HRA, other applicable assessments or tasks need to be completed, the ECM LCM should set up a task in CCA to set a reminder to complete these assessments/tasks.

Follow the steps below to access the CA HRA in CCA:

INSTRUCTIONS	SCREENSHOT
Step 1: Access the **Assessment** module There are multiple ways to access Assessments, the shortcut is displayed.	 **Or…**

INSTRUCTIONS	SCREENSHOT
	
Step 2: Select Assessment Under Category type in CA to filter the list Select California Assessments [**CA HRA]** Click Take assessment Or Retake if it was previously completed.	  

INSTRUCTIONS	SCREENSHOT
Step 3: Complete Assessment Complete the assessment with the member in its entirety. Ensure that all questions are addressed and answered. Provide additional detail in the drop-down fields where applicable (i.e., conditions, cognitive issues, PHQ2, etc.). The final Screen is displayed with the option to view the completed assessment.	

Setting-up HRA Reassessment Task Reminders

Molina's ECM Team requires that our ECM LCMs set up task reminders in CCA to ensure they complete the HRA Reassessment with our members within six months from the last HRA. Refer to the ***Task Function*** section for steps on setting up task reminders.

Condition-Specific Assessments

Molina's CA-HRA is a comprehensive assessment. Additional assessments may need to be completed based on the member's responses to the HRA. The HRA and additional assessments would be the basis for developing the person-centered ECM Care Plan.

Within the CA-HRA are embedded screening tools for *substance use disorders, depression, cognitive decline, and caregiver fatigue/stressors/needs.*

Substance Use Disorders

The *CAGE-AID* is an evidence-based screening tool for Substance Use Disorders (SUDs) named as an acronym based on the questions within. ***CAGE***: **C**ut back, **A**nnoyed, **G**uilty, **E**ye Opener. ***AID***: **A**dapted to **I**nclude **D**rugs.

The *CAGE-AID* can only be administered directly to a member if the *CA-HRA* is completed with a proxy, type *member not available* as a reason not addressed.

Based upon member's responses, if the *CAGE* is positive and/or there is a suspicion of a SUD, further assessment is indicated:

1. *The American Society of Addiction Medicine Assessment* (ASAM)
2. *The National Institute on Drug Addiction Assessment* (NIDA)

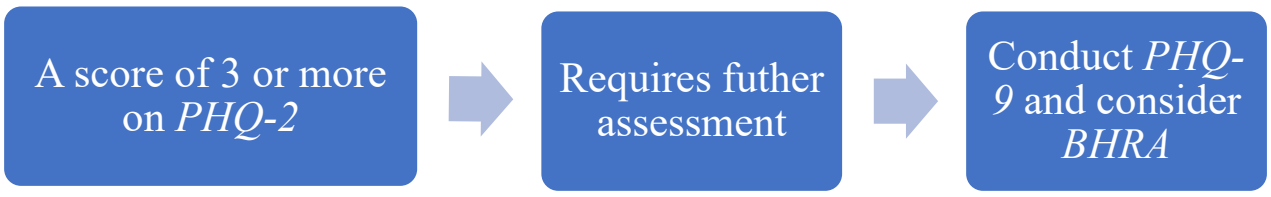
Depression

The *Patient Health Questionnaire 2 item version* (PHQ-2) is an evidence-based screening tool for depressive symptoms over a previous 2-week span.

The *PHQ-2* can only be administered directly to a member. If the *CA-HRA* is completed with a proxy, type *member not available* as a reason not addressed

If a *PHQ2* is positive, further assessment is indicated:

1. Based on members' responses, the PHQ-9 may be triggered for completion.

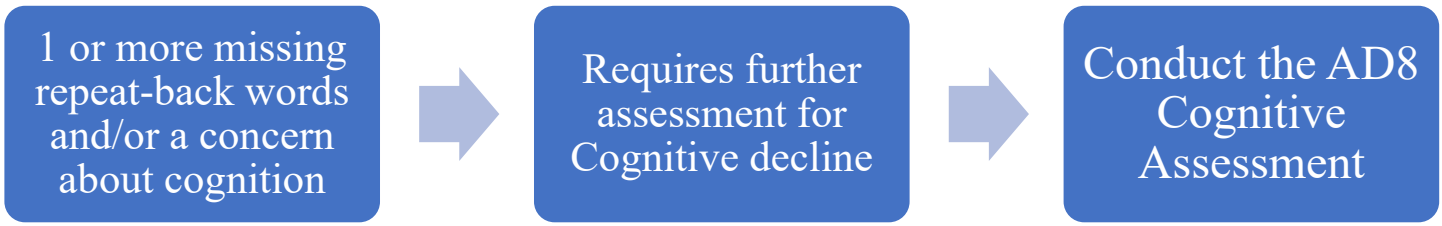


2. At ECM Provider discretion: The Behavioral Health Risk Assessment (BHRA)

Cognitive Decline

To screen for cognitive decline, there is a mini-cognition exam consisting of three repeat-back questions and a direct question asking if the participant or caretaker has concerns about memory/cognition. If one or more repeat-back words are incorrect or missing, and/or there is a stated/observed concern about cognition, further assessment is indicated:

1. The *8-item Informant Interview to Differentiate Aging and Dementia* (AD-8). * Assessment is NOT needed if the participant is already diagnosed with Dementia or Alzheimer's Disorder. * Assessment may be administered to the participant or caregiver.



Caregiver Fatigue/Stressors/Needs

To screen for caregiver fatigue/stressors/needs, there are questions asking the participant if they need help with daily functions and if the caregiver has a hard time meeting the participant's needs.

1. The Caregiver Self-Assessment Questionnaire is designed to assess informal and family caregivers. An informal caregiver may be paid (as with a family member working as an IHSS provider) or unpaid.

Connect the caregiver to appropriate community resources for additional support.

Condition Specific-Assessments are also available for the following conditions:

Asthma	CHF	COPD
Diabetes	ESRD	Hypertension
Pain Management		

There are also condition specific-assessments specific for children:

- Peds-Asthma
- Pediatric Symptoms Checklist (PSC-17) – this is the version of the PHQ-9 that should be used for individuals under 18 years of age

Steps for Assessing Members:

1. We reveal the purpose of the assessment to the participant and ask permission to proceed
2. We collect data by asking questions
3. We create an informed, individualized health action plan based on the information/needs identified.
4. We share the results of assessments with the member, PCP, and relevant providers.

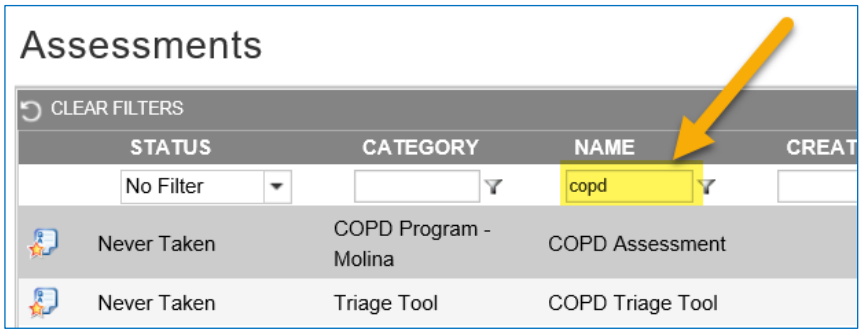
Enhanced Care Management Assessments

The following condition-specific assessments are recommended to be utilized as appropriate for the member, depending on responses per the CA-HRA. Condition-specific assessments should be completed as needed to monitor the member's conditions and related symptoms.

1. AD 8 Cognitive Screening
2. AMA Caregiver Assessment
3. ASAM Substance Abuse Assessment
4. Asthma
5. Behavioral Health Assessment Adolescent and Child
6. Behavioral Health Assessment Adult
7. CDK - **Follow-up completed quarterly*
8. Congestive Heart Failure (CHF) Assessment
9. COPD
10. Depression Initial Assessment
11. Diabetes
12. ESRD (Initial) - **Follow-up completed quarterly*
13. Hypertension
14. Pain Management Assessment
15. Pediatric Asthma Assessment
16. Pediatric General Care Management Assessment
17. Pediatric Symptoms Checklist (PSC-17)
18. Peds QL Child 5 to 7
19. Peds QL Child 8 to 12
20. Peds QL Parent 13 to 18
21. Peds QL Parent 2 to 4
22. Peds QL Parent 5 to 7

23. Peds QL Parent 8 to 12
24. Peds QL Teen 13 to 18
25. Peds QL Young Adult 18 to 25
26. PHQ-9

To find specific assessments to administer, type the name of the assessment into the name box in the Assessment section of CCA (see the list below of Molina Condition-Specific Assessments available in CCA):



Trauma-Informed Screening- Teen/Children

Under Molina's ECM Program, a trauma-informed assessment tool is required and must be added to the existing assessment and planning tools. The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the ECM LCM for all ECM opt-in members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities, such as county agencies or volunteer support entities, the ECM LCM will work with the ECM member and their family/support persons to develop an ECM Care Plan. **All children** who have opted-in to the ECM must be screened using the trauma-informed assessment tool during each comprehensive Health Risk Assessment (HRA) administration.

What is Trauma-Informed Care?

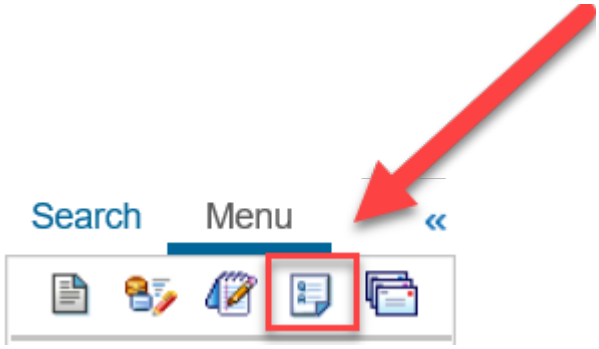
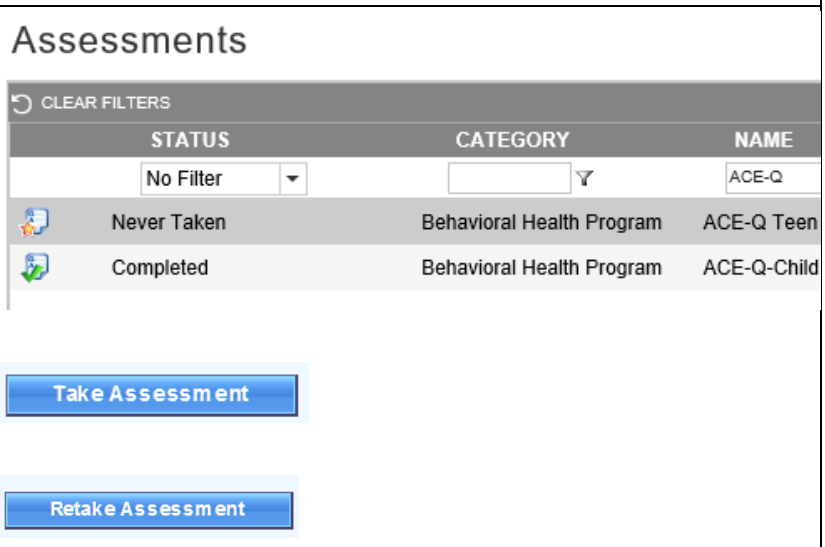
Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma (physical, psychological, sexual, neglect, and emotional). Trauma-informed care emphasizes safety (physical, psychological, and emotional) for members and providers and seeks to empower members with self-care tools (ECM Program Guide).

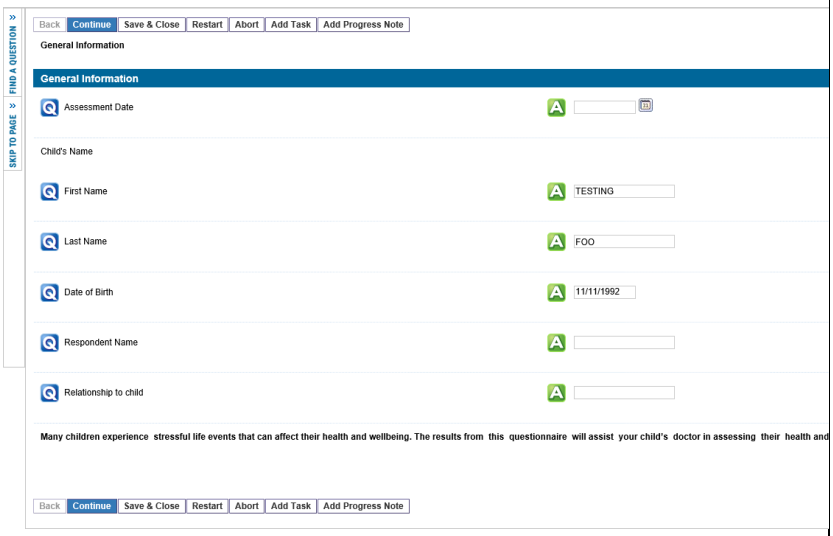
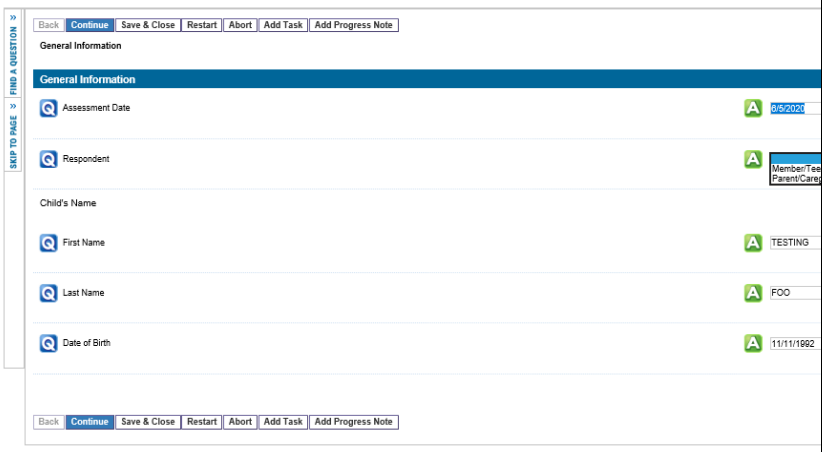
Screening for trauma symptoms, especially concerning determining how trauma affects health outcomes, is essential in determining a member's overall social and emotional well-being. Assessing for trauma is critical to providing trauma-informed care and should be indicated in the member's ECM Care Plan as appropriate. For children, the recommended tool is the Adverse Childhood Experiences Questionnaire (ACE-Q).

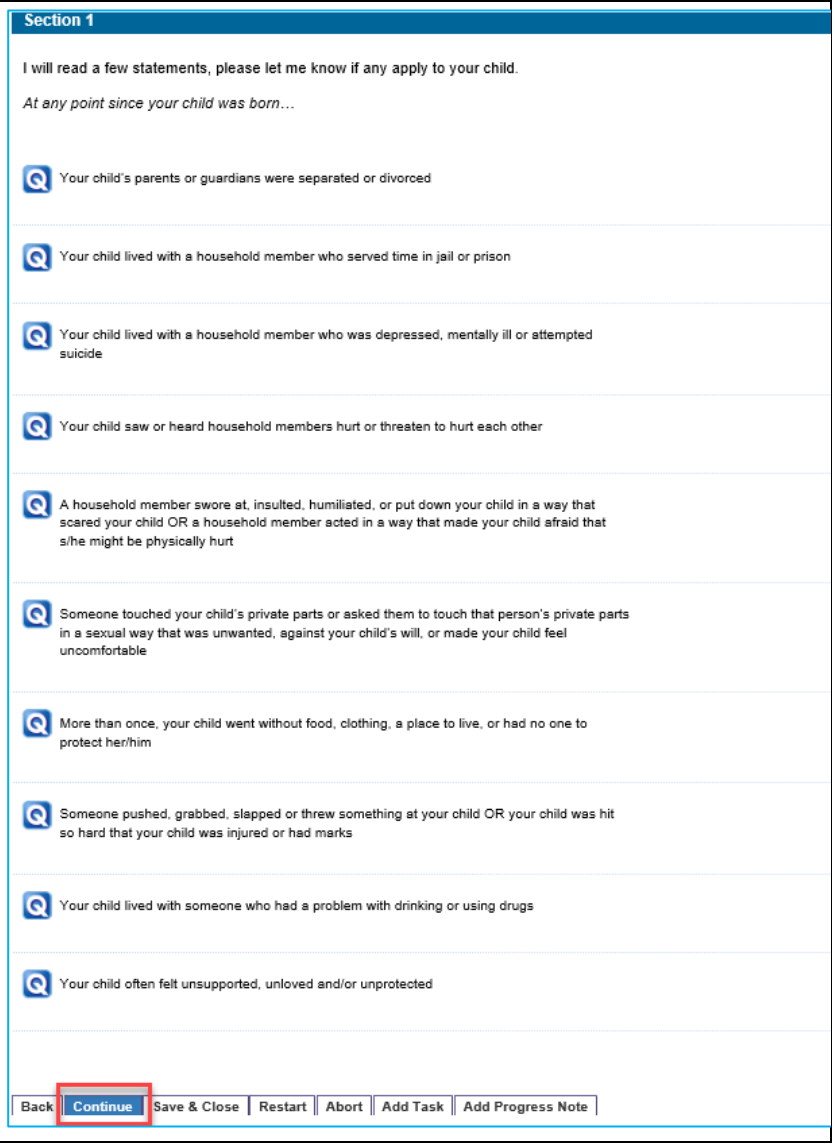
What is the ACE-Q?

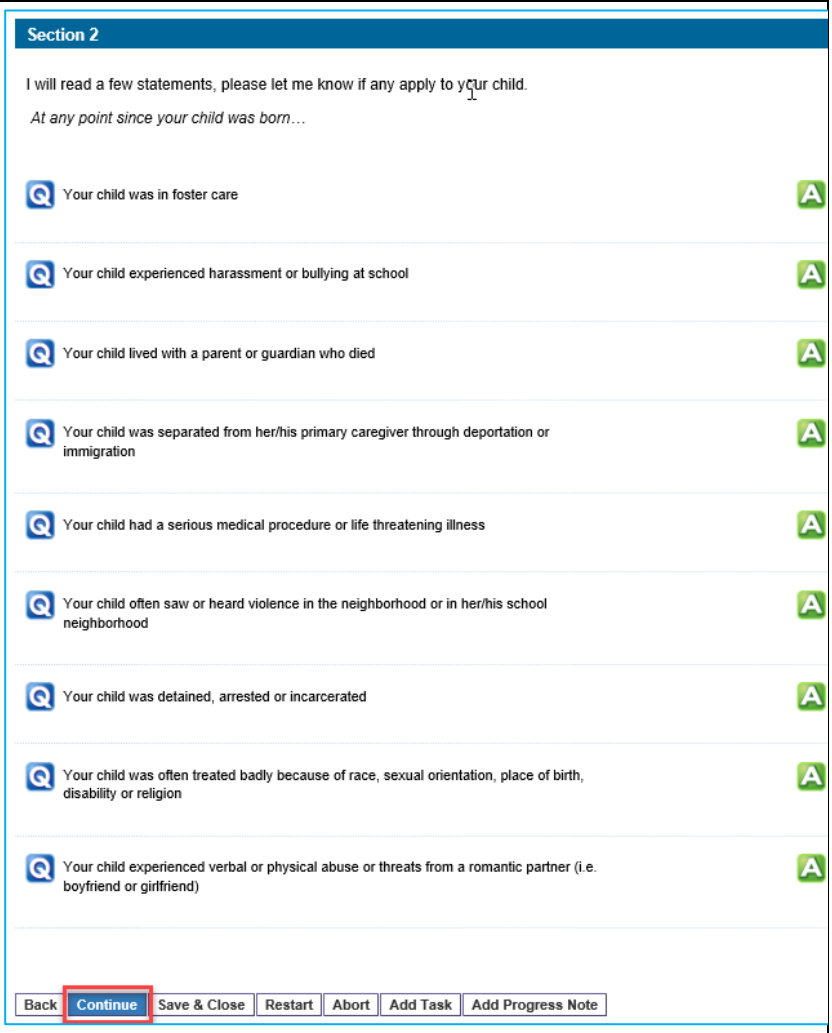
The ACE-Q is a clinical screening tool that calculates cumulative exposure to Adverse Childhood Experiences (ACEs) in patients aged 0 to 19. Respondents are asked to report how many experience types (or categories) apply to them or their child. The ACE-Q is to identify patients at increased risk for chronic health problems, learning difficulties, mental and behavioral health problems, and developmental issues due to changes in brain architecture and developing organ systems brought on by exposure to extreme and prolonged stress. It takes approximately two to five minutes to complete.

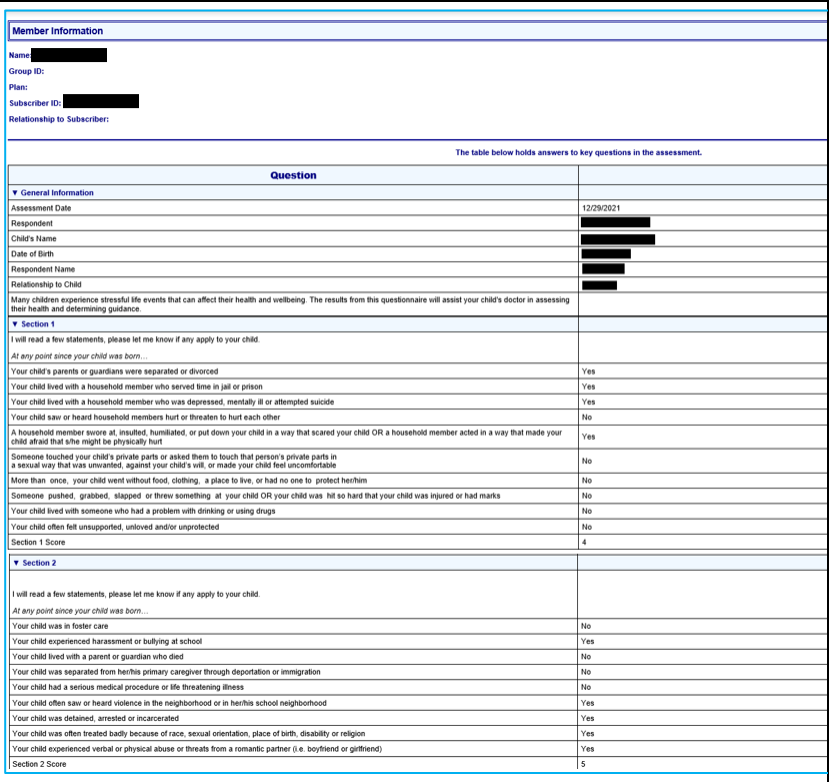
Follow the steps below to prompt the Adverse Childhood Experiences Questionnaire (ACE-Q) in CCA:

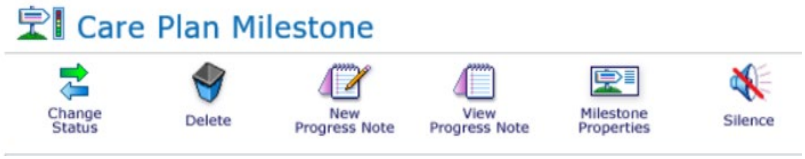
INSTRUCTIONS	SCREENSHOT
Step 1: Access Module There are multiple ways to access Assessments; the shortcut is displayed.	
Step 2: Select Assessment Under 'Name,' search for 'ACE-Q' to filter the list Select the age-appropriate trauma-informed screener: ACE-Q Child or ACE-Q Teen. Click **Take** assessment Or **Retake** if it was previously completed.	
Step 3: Complete Section – General Information	Proceed to Step 3a if the assessment is for a child. Proceed to Step 3b if the assessment is for a teen.

INSTRUCTIONS	SCREENSHOT
Step 3a: Complete Section – General Information – ACE-Q Child Complete the general information with Parent/Caregiver. Select 'Continue' to proceed.	ACE-Q-Child 
Step 3b: Complete Section Continued – General Information – ACE-Q Teen Complete the general information with either Member/Teen or Parent/Caregiver. Select 'Continue' to proceed.	ACE-Q Teen 

INSTRUCTIONS	SCREENSHOT
Step 4: Complete Section – ACE-Q Section 1 A response of 'Yes' or 'No' is required for each question in this section. Do not leave any blanks, as that will impact the scoring. Select 'Continue' to proceed.	

INSTRUCTIONS	SCREENSHOT
Step 5: Complete Section – ACE-Q Section 2 A response of 'Yes' or 'No' is required for each question in this section. Do not leave any blanks, as that will impact the scoring. Select 'Continue' to proceed.	
Step 6: Complete Section – Click on View Report Click on 'View Report.' The following screen will automatically produce a score based on the member's responses.	

INSTRUCTIONS	SCREENSHOT
Step 7: Complete Section – View Report and Calculate Add 'Section 1 Score' with 'Section 2 Score.' If the member scores three or more on the ACE-Q Child or ACE-Q Teen, move on to Step 8. The inventory is complete if the member/caregiver scores less than three. *No numeric score indicates an incomplete response to Section I and/or Section II. Please review and re-take the assessment.	 **Member Information** Name: [redacted] Group ID: Plan: Subscriber ID: [redacted] Relationship to Subscriber: The table below holds answers to key questions in the assessment. **Question** ▼ General Information Assessment Date: 12/29/2021 Respondent: [redacted] Child's Name: [redacted] Date of Birth: [redacted] Respondent Name: [redacted] Relationship to Child: [redacted] Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. ▼ Section 1 I will read a few statements, please let me know if any apply to your child. *At any point since your child was born…* Your child's parents or guardians were separated or divorced: Yes Your child lived with a household member who served time in jail or prison: Yes Your child lived with a household member who was depressed, mentally ill or attempted suicide: Yes Your child saw or heard household members hurt or threaten to hurt each other: No A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt: Yes Someone touched your child's private parts or asked them to touch that person's private parts in a sexual way that was unwanted, against your child's will, or made your child feel uncomfortable: No More than once, your child went without food, clothing, a place to live, or had no one to protect her/him: No Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks: No Your child lived with someone who had a problem with drinking or using drugs: No Your child often felt unsupported, unloved and/or unprotected: No Section 1 Score: 4 ▼ Section 2 I will read a few statements, please let me know if any apply to your child. *At any point since your child was born…* Your child was in foster care: No Your child experienced harassment or bullying at school: Yes Your child lived with a parent or guardian who died: No Your child was separated from her/his primary caregiver through deportation or immigration: No Your child had a serious medical procedure or life threatening illness: No Your child often saw or heard violence in the neighborhood or in her/his school neighborhood: Yes Your child was detained, arrested or incarcerated: Yes Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion: Yes Your child experienced verbal or physical abuse or threats from a romantic partner (i.e. boyfriend or girlfriend): Yes Section 2 Score: 5
Step 8: Scoring If the member/caregiver scores three or more, refer the member to an existing or new BH Provider for further evaluation and treatment.	A score of 3 or more on the ACE-Q Child or ACE-Q Teen indicates that the member may suffer from trauma requiring further exploration and assessment from a healthcare professional. If the member does not have an existing BH Provider and scores three or more, link the member with a Molina In-Network BH Provider for further evaluation and treatment. The ACE-Q Child or ACE-Q Teen should only be conducted once during each HRA assessment.
Step 9: Communicate Results with PCP	Share the ACE-Q Child or ACE-Q Teen results with the member's primary care physician and existing BH Provider, regardless of the score. Include the ACE-Q Child or ACE-Q Teen Report with the Provider Letter. Follow-up with member's primary care physician and existing BH Provider via phone call.
Step 10: Complete the ECM Care Plan	Please refer to the Care Plan guidance below to develop the problem, goal, intervention, and barrier.
Note:	The member has the right to silence their goal, intervention, and outcome in the ECM Care Plan. Please note that each part of the ECM Care Plan must be silenced individually using the yellow file beside the goal, intervention, and outcome.

INSTRUCTIONS	SCREENSHOT
	

Trauma-Informed Screening- Adults

Under Molina's ECM Program, a trauma-informed assessment tool is required and must be added to the existing assessment and planning tools. The assessments must be available to the primary care physicians, mental health service providers, substance use disorder services providers, and the ECM LCMs for all ECM opt-in members. In conjunction with the primary care physician, other multi-disciplinary care team members, and any necessary ancillary entities, such as county agencies or volunteer support entities, the ECM LCM will work with the ECM member and their family/support persons to develop an ECM Care Plan. Members who have opted-in to the ECM must be screened using the trauma-informed assessment tool if indicated during each comprehensive Health Risk Assessment (HRA) administration.

What is Trauma-Informed Care?

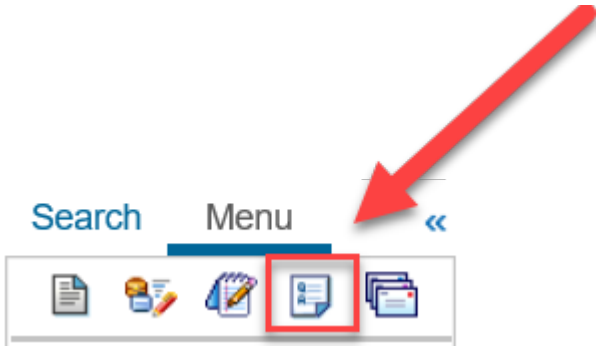
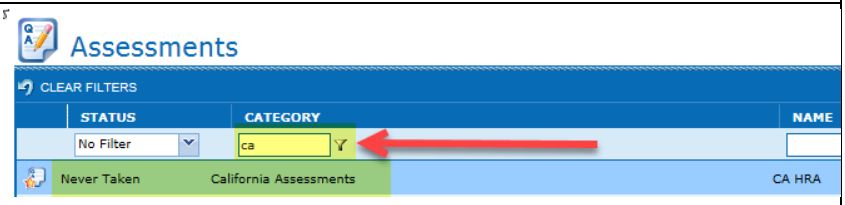
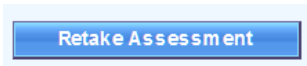
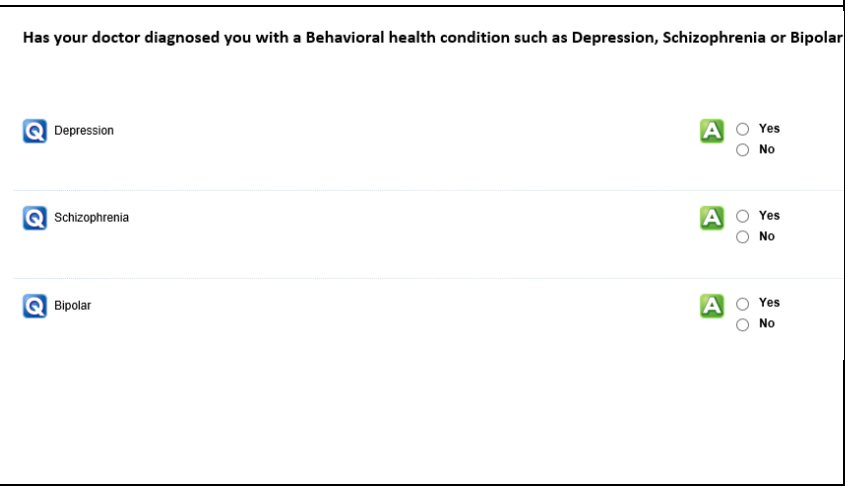
Trauma-informed care is a service delivery framework that involves identifying, understanding, and responding to the effects of all types of trauma (physical, psychological, sexual, neglect, and emotional). Trauma-informed care emphasizes safety (physical, psychological, and emotional) for members and providers and seeks to empower members with self-care tools.

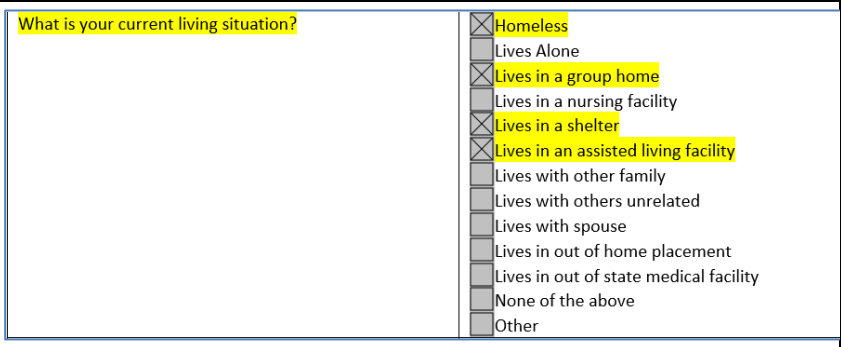
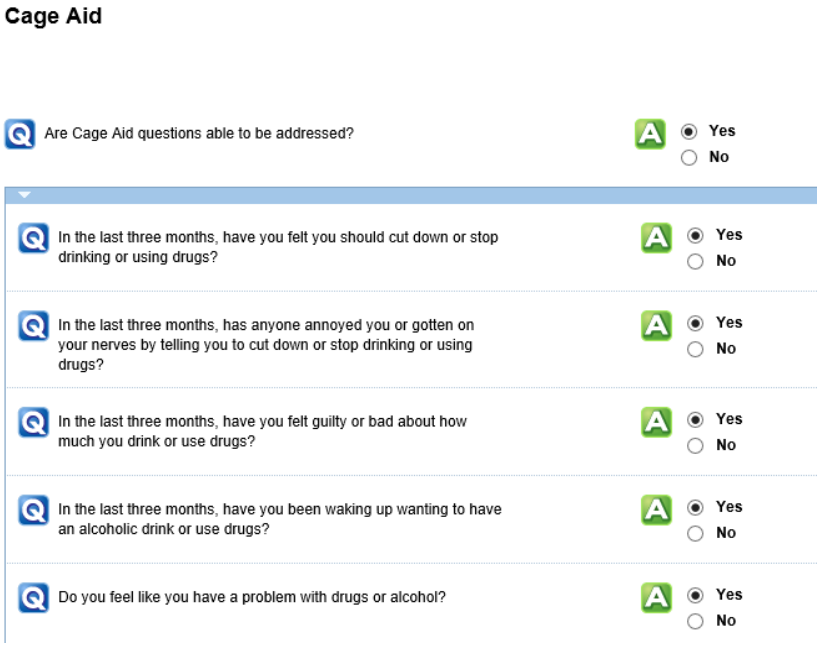
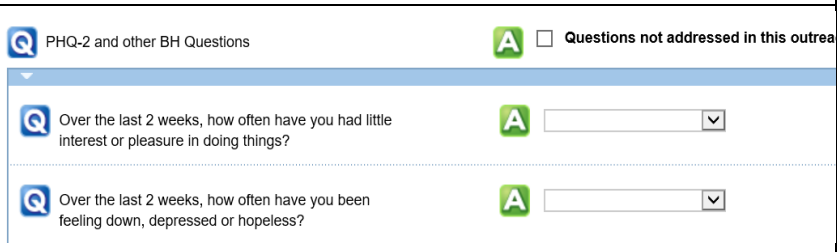
Screening for trauma symptoms, especially concerning determining how trauma affects health outcomes, is essential in determining a member's overall social and emotional well-being. Assessing for trauma is critical to providing trauma-informed care and should be indicated in the member's ECM Care Plan as appropriate. For adults, the recommended tool is the PC-PTSD-5 Screening Tool.

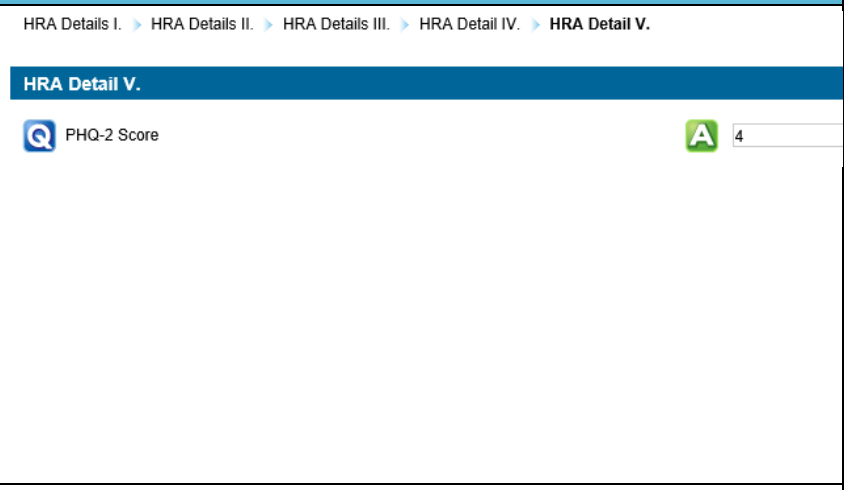
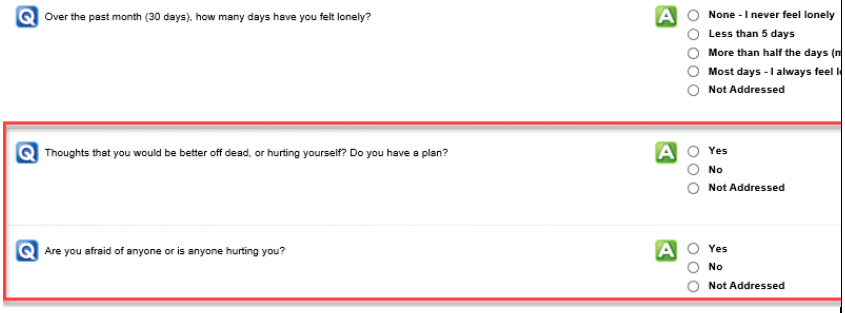
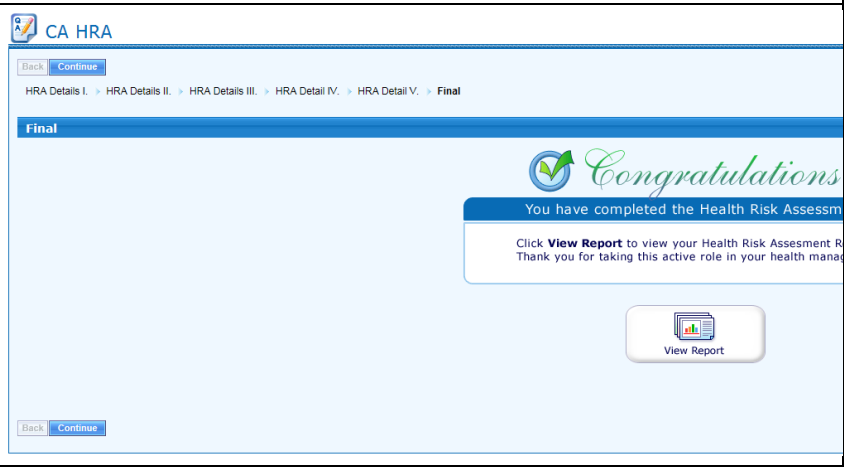
What is the PC-PTSD-5 Screening Tool?

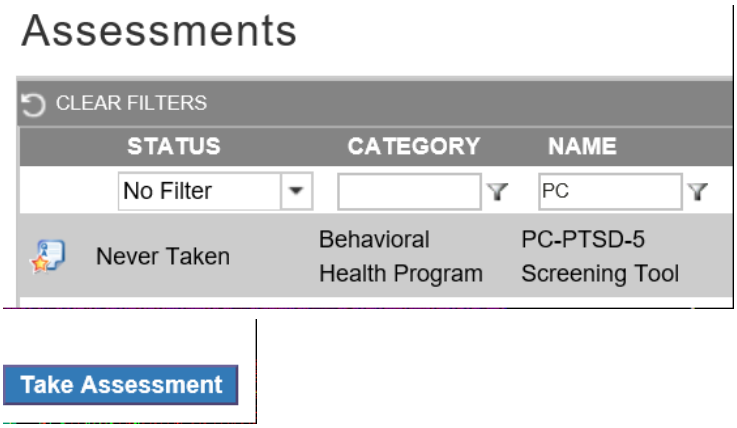
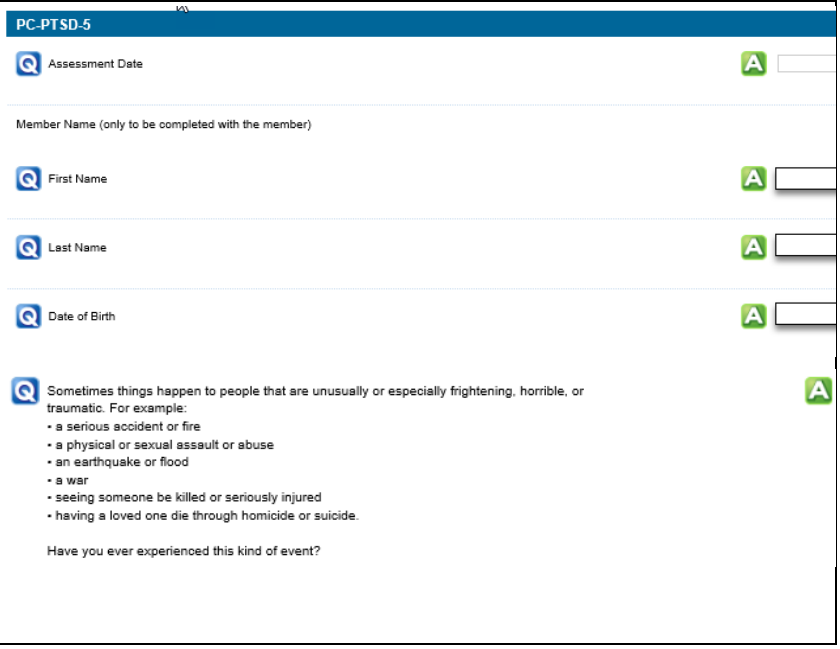
The Primary Care Posttraumatic Stress Disorder (PTSD) Screen for DSM-5 (PC-PTSD-5) is a 5-item screen designed to identify adults with probable PTSD and/or Stressor-Related Disorders. Those who screen positive require further assessment, preferably with a structured interview. Please see *The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)* for more information.

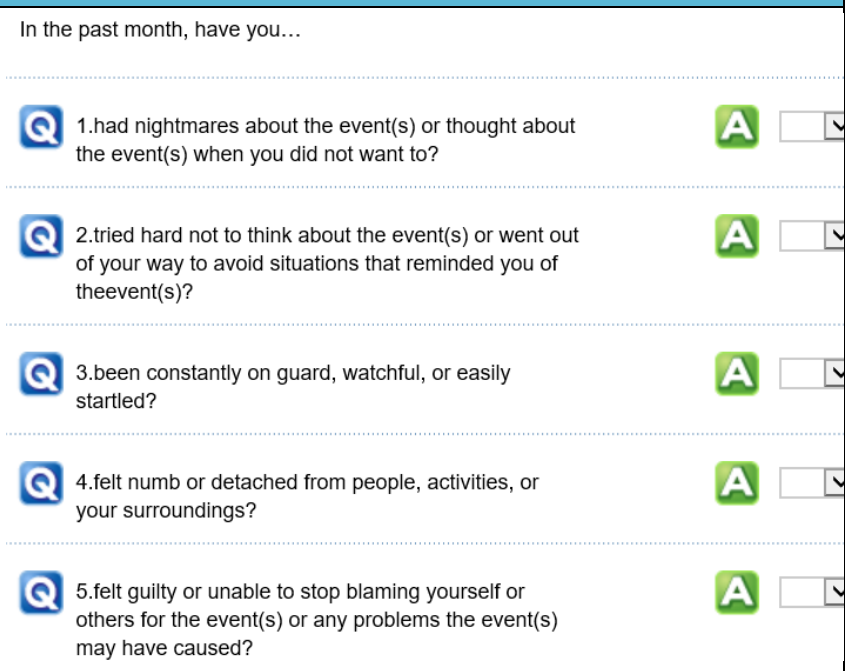
Follow the steps below to prompt the Trauma Informed Screening Tool in CCA:

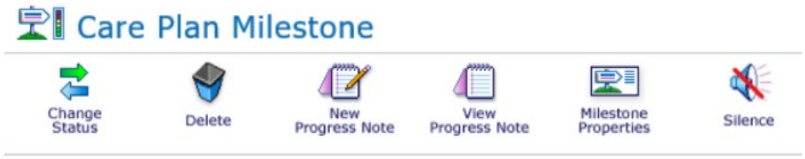
INSTRUCTIONS	SCREENSHOT
Step 1: Access Module There are multiple ways to access Assessments, the shortcut is displayed.	
Step 2: Select Assessment Under Category type in CA to filter the list Select California Assessments: CA HRA Click Take assessment Or Retake if it was previously completed.	  
Step 3: Complete Section -HRA Details II Complete Behavioral Health Conditions with the member. If the member responds 'Yes' to any Behavioral Health Conditions, complete the PC-PTSD-5 with the member.	

INSTRUCTIONS	SCREENSHOT
Step 4: Complete Section -HRA Details III. If the member selects any of the following highlighted drop-down current living conditions, complete the PC-PTSD-5.	
Step 5: Complete Section -HRA Details IV Complete the Cage Aid. If the member responds 'Yes' to the following questions, complete the PC-PTSD-5 and ASAM Screener.	
Step 6: Complete Section Continued -HRA Details IV Complete the PHQ-2 and other BH Questions with the member. The following screen will automatically produce a score based upon the member's responses.	

INSTRUCTIONS	SCREENSHOT
Step 7: Complete Section -HRA Details V A score of 2 or less does not require 1) PHQ-9 Assessment and 2) PC-PTSD-5. If the member scores three or more on the PHQ-2, then the PHQ-9 and the PC-PTSD-5 should be completed.	
Step 8: Complete Section -HRA Detail V If the member selects 'Yes' to the following two drop-down questions, complete the PC-PTSD-5. If the member is in active crisis, follow steps 1 through 5 and suspend completion of PC-PTSD-5. PC-PTSD-5 is to be completed at a later time when a member is safe.	
Step 9: Complete the Assessment Complete the assessment with the member. The final Screen is displayed with the option to view the completed assessment.	

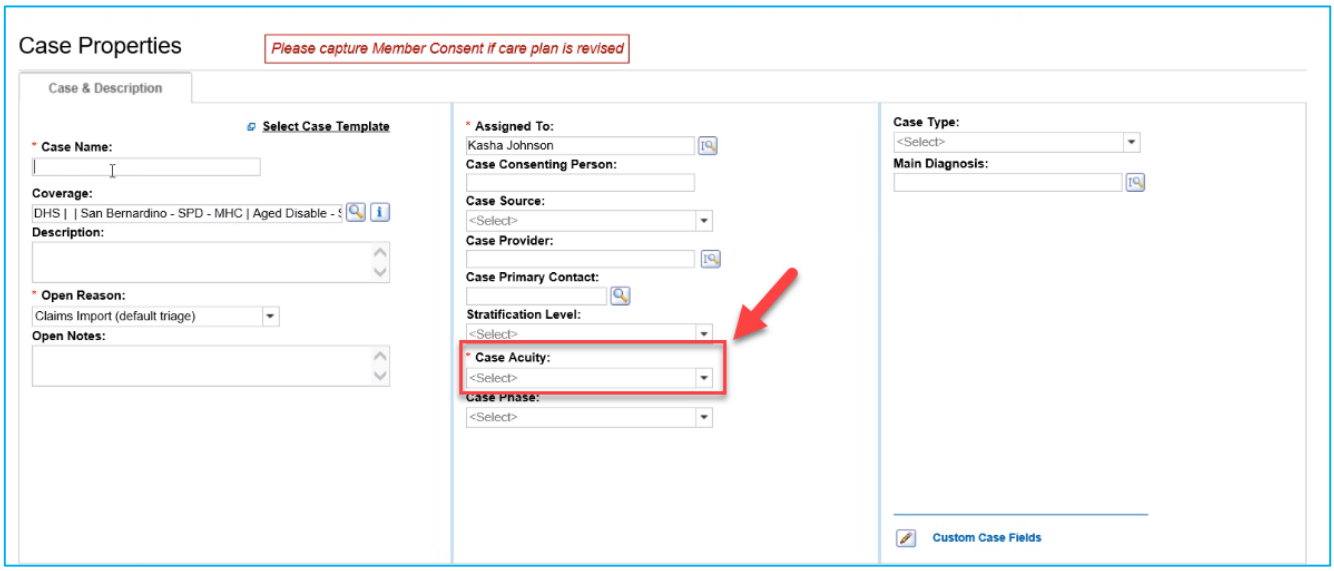
INSTRUCTIONS	SCREENSHOT
Step 10: Select Assessment Locate the PC-PTSD-5 in the 'Assessments' section in CCA. Under NAME, type in PC to filter the list Select PC-PTSD-5 Screening Tool Click Take Assessment	
Step 11: Complete Section Enter the Assessment Date An automated drop-down will appear if the member responds 'yes' to the following experiences. If the member responds 'no,' then PC-PTSD-5 has been completed.	

INSTRUCTIONS	SCREENSHOT
Step 12: Complete Section Ask the member the following set of questions.	
Step 13: Scoring If the member responds 'yes' to three or more of the following five questions, refer the member to an existing or new BH Provider for further evaluation and treatment.	 A score of 3 or more on the PC-PTSD-5 indicates that the member may suffer from trauma requiring further exploration and assessment from a healthcare professional. If the member does not have an existing BH Provider and scores three or more, link the member with a Molina In-Network BH Provider for further evaluation and treatment. The PC-PTSD-5 should only be conducted once during each HRA assessment.
Step 14: Communicate Results with PCP	Share the results from the PC-PTSD-5 with the member's primary care physician and existing BH Provider if applicable, regardless of the score. Include the PC-PTSD-5 Report with the Provider Letter. Please reference the attachment titled PC-PTSD-5 Provider Letter. Follow-up with member's primary care physician and existing BH Provider via phone call.
Step 15: Complete the ECM Care Plan	Please refer to the ECM Care Plan Guide to develop the problem, goal, and intervention.
Note:	The member has the right to silence their goal, intervention, and outcome in the ECM Care Plan. Please note that each part of the ECM Care Plan must be

INSTRUCTIONS	SCREENSHOT
	silenced individually using the yellow file beside the goal, intervention, and outcome. 

Case Management Acuity

ECM members must be assigned an acuity level when the ECM LCM creates the care plan in CCA (see screenshot below). The appropriate acuity level must be selected based on the member's needs and may change during the member's enrollment in ECM. Low acuity members should NOT be enrolled in the ECM program. Low acuity members should be re-evaluated to determine if the member requires ECM level of intensive care coordination services. If the member no longer needs ECM services because the member is well-managing conditions, the member should be graduated from ECM as "All Care Plan Goals Met."



Medium Acuity

If your organization's assigned ECM members fall under the following criterion, the member is considered Medium Acuity. Members of Medium Acuity should be re-evaluated every six months to determine continued eligibility for ECM.

- Maternity High Risk
- Three or four co-morbid conditions
- Targeted diagnosis with two admits within six months
    - CVD
    - CHF
    - COPD
    - ESRD
    - Asthma
    - Diabetes
    - Sickle Cell
    - AIDS/HIV
    - Cancer
    - Behavioral Health (specific codes)
- Three to five avoidable Emergency Department visits within six months
- Minimum required face-to-face visits: One (1) visit per quarter. However, the frequency could be greater depending on the member's needs.

High Acuity

If any of your organization's assigned ECM members fall under the following criterion, the member is considered High Acuity.

- Five or more co-morbid conditions
- Reports health as poor
- High-risk chronic illness with clinical instability as demonstrated by three or four admits within six months related to:
    - CVD
    - CHF
    - COPD
    - ESRD
    - Asthma
    - Diabetes
    - Sickle Cell
    - AIDS/HIV
    - Cancer
    - Behavioral Health (specific codes)
- Six or more avoidable Emergency Department visits within six months
- Minimum required face-to-face visits: One (1) visit per month. However, the frequency could be greater depending on the member's needs.

Catastrophic Acuity

If any of your organization's assigned ECM members fall under the following criterion, the member is considered Catastrophic Acuity.

- High-risk chronic illness with clinical instability as demonstrated by five or more admits in six months related to:
    - CVD
    - CHF
    - COPD
    - ESRD
    - Asthma
    - Diabetes
    - Sickle Cell
    - Aids/HIV
    - Cancer
    - Behavioral health (specific codes)
- Imminent risk of:
    - Inpatient admissions (psychiatric or medical) related to the inability to self-manage in the current living environment
    - Institutionalization
- Need assistance with four or more activities of daily living, independent activities of daily living, and lacks adequate caregiver assistance.
- Minimum required face-to-face visits: Two (2) visits per month. However, the frequency could be greater depending on the member's needs.

Care Plan

The care plan will be created with the member within 90 days of enrollment. As a best practice, the ECM LCM should complete the care plan within 2 business days of CA-HRA completion to encourage engagement with the member. Each member should only have ONE active care plan. Problems and concerns identified in the CA-HRA should be addressed in the member's care plan, which includes areas the member is self-managing. If the member refuses to work on an identified need, the ECM LCM must clearly document via a Contact Form in CCA. The care plan includes but is not limited to member's identified concerns, goals, and preferences in the areas of physical health, mental health, SUD community-based LTSS, palliative care, trauma-informed care needs, social support, and housing (as appropriate for individuals experiencing homelessness), with measurable objectives and timeframes, and should evolve as the member's needs change, as indicated by the member's HRA and other assessments.

The care plan should have customized interventions to ensure its specific to the member's needs and goals. The ECM LCM needs to develop a comprehensive, individualized, person-centered care plan that coordinates and integrates the member's clinical and non-clinical healthcare-related needs. The care plan communication must be done in a culturally relevant and linguistically appropriate manner. The ECM LCM needs to coordinate services based on risk stratification results, CA-HRA, comprehensive assessments, clinical data, emergency and hospital utilization, behavioral health utilization, screening tools, Long Term Services and Supports (LTSS)/Home and Community-Based Services (HCBS) assessments, and other data when provided.

The following guidelines apply to the Care Plan:

- The member's main health concern must be clearly integrated into the care plan. This may not always be related to health. This can be integrated into any of the problems/milestones developed.
- Self-management activities can be listed within condition-specific interventions.
- Barriers address the condition or event that may delay or prevent reaching plan goals. All identified barriers related to each goal are member-centric, documented, and incorporated into the corresponding milestone. Each problem, goal, and intervention must have a barrier. Standard barriers are in the Library (CCA) as Barriers to Goals.
- Additional conditions/problems: choose conditions/problems identified in the assessment, conditions that put the member at risk for deterioration in health status/unstable conditions (homeless, inadequate caregiver), and conditions that need immediate attention/clinical (e.g., behavioral health, Transitions of Care (ToC), Continuity of Care (COC) needs, etc.)
    - Clinical (e.g., behavioral health, transition of care, continuity of care, etc.)
        - Also include ways members are self-managing their conditions, or
    - Non-clinical (e.g., homeless, inadequate caregiver support, personal goal, etc.)
- For individualized milestones, goals, and interventions, use the member's language when possible (member-directed goals)
- Measurable outcomes with *numeric values* or words *teach back* or *repeat back* to promote self-management
- A mixture of short-term and long-term goals
    - Member prioritized long-term goal (>60 days) – at least one (1)
    - Member prioritized short-term goal (≤60 days) – at least one (1)
- The care plan should consistently address member care gaps identified through the CA-HRA and through discussion with member/caregiver.
- The ECM LCM should coordinate ICT meetings and document occurrences via a Contact Form in CCA. The contact form must clearly identify who attended the ICT in the notes section and information shared with those involved as part of the member's multi-disciplinary care team. Refer to the "Case Conference" section for more information on ICT meetings.
- The care plan should show evidence of Health Promotion activities supporting the member's learning and adopting healthy lifestyle choices, including providing the member with appropriate educational

material. Refer to Healthwise Knowledge Base in CCA for education materials. Health education material must be culturally appropriate and provided in multiple formats for members with disabilities.

- The care plan should not have any overdue milestones. The care plan should consistently be updated at a frequency appropriate for the member, especially when there is a change in condition, upon reassessment, care conference and/or care plan progress updates; however, no later than six months from the last care plan update. This includes administering a new CA-HRA to identify new problem areas.
    - Anytime the care plan is updated, the ECM LCM needs to enter a Contact Form in CCA and enter "Care Plan Development/Revision," along with "ECM" under the purpose of contact.
- ECM LCM is required to provide a copy of the completed care plan to the member and/or their representative and the member's PCP; after creating the care plan (within 90 days from opting in a member, Best Practice: within three business days from completion of the care plan) and anytime the care plan is updated (within **14 business days** of updating the care plan) in addition to mailing the ECM Care Plan Letter to the member and the ECM PCP Care Plan Letter to the member's PCP. After completing these tasks, the ECM LCM must complete a Contact Form in CCA and ensure the appropriate letters are mailed. If the member declines to receive a copy of the care plan and ECM Care Plan Letter, the ECM LCM will clearly document this via a Contact Form in CCA.
- The ECM LCM needs to note via a Contact Form in CCA when they plan to follow up with the member on their care plan progress. It is also recommended to create a task as a reminder to follow up.
- Acuity needs to be appropriate based on members' needs and conditions and documented in the Case Properties.
- The care plan should address the member's needs and conditions, including but not limited to the following elements, as applicable:
    1. Physical and developmental health
    2. Mental health
    3. Dementia
    4. Substance Use Disorders (SUD)
    5. Oral Health
    6. Palliative care
    7. Trauma-informed care
- The care plan should have evidence of addressing all applicable community-based services, including LTSS, social services, and housing needs when applicable to the member.
- ECM LCM should support the member in their treatment, including but not limited to:
    1. Coordination for medication review and/or reconciliation
    2. Scheduling appointments
    3. Providing appointment reminders
    4. Coordinating transportation
    5. Accompaniment to critical appointments
    6. Identifying and helping to address other barriers to member engagement in treatment.
- The Contact Forms in CCA should demonstrate the ECM LCM requested a referral from the MCP for MCP-aligned community services that address social determinants of health (SDOH) needs. The ECM LCM should follow up with MCP and members to ensure that care gaps are closed and that community services were rendered as requested (i.e., "closed loop referrals"). The Contact Forms in CCA should demonstrate requesting a referral from the MCP for MCP-aligned community services, such as Community Support, which address SDOH needs.
- The care plan should ensure that the member and chosen family/support persons, including guardians and caregivers, are knowledgeable about the member's condition(s) to improve the member's care planning and follow-up, adherence to treatment, and medication management.
- The ECM LCM should use strategies to reduce avoidable emergency department visits, admissions, or readmission for the member. The ECM LCM should be documenting these care coordination services/activities via a Contact Form in CCA and provide as much detail as possible in the notes section. Examples include, but are not limited to, the following, as needed:
    1. Ensuring follow-up appointments are scheduled post-discharge.

2. Medication adherence post hospital discharge.
3. Home safety checks are ordered and completed as necessary.
4. Independent living aids (e.g., stair lifts, wheelchairs, walkers, Hoyer lifts, life alerts).
5. Home health nurse ordered.
6. Care person ordered to assist in activities of daily living (ADLs).

- The ECM LCM must track and evaluate a member's medical care needs and coordinate any support services to facilitate safe and appropriate transitions from and among different settings, including admissions/discharges to/from:
    1. Emergency department
    2. Hospital inpatient facility
    3. Skilled nursing facility
    4. Residential/treatment facility
    5. Incarceration facility
    6. Other treatment center

SMART Goals

Care plan goals should be measurable and in a SMART format. Refer to the guidelines below for SMART goals:

The SMART acronym can help us remember these components

SPECIFIC The goal should identify a specific action or event that will take place.

(Who? What? Where? When? Why?)

MEASURABLE The goal and its benefits should be quantifiable.

(How many? How much?)

ACHIEVABLE The goal should be attainable given available resources.

(Can this really happen? Attainable with enough effort? What steps are involved?)

REALISTIC The goal should require you to stretch some but allow the likelihood of success

(What knowledge, skills, and abilities are necessary to reach this goal?)

TIMELY The goal should state the time period in which it will be accomplished.

(Can I set fixed deadlines? What are the deadlines?)

Tips To Help Set Effective Goals

- **Develop a minimum of one goal for each letter of the SMART acronym.** This allows multiple channels to assist the member in care coordination over time.
- **State goals as declarations of intention, not items on a wish list.** "I want to lose weight" lacks power. "I will lose weight" is intentional and powerful.

- **Attach a date to each goal.** State what you intend to accomplish and by when. A good list should include some short-term and some long-term goals. You may want a few goals for the year and some for two- or three-month intervals.

- **Be specific.** "To improve my HbA1c" is too general; "To track my HbA1c in my smartphone daily to monitor my HbA1c" is better. Sometimes a more general goal can become the long-term aim, and you can identify some more specific goals to take you there

- **Self-Management.** Make sure interventions include a mixture of member and CM actions.
- **Share care plan goals.** Sharing the Plan's care management intentions with the PCP will help ensure success.

- **Write down your goals and put them where you will see them.** Keep the member's care plan in mind and refer to it often! The more often you read the list, the more results you get.

- **Review and revise the care plan as needed.** Experiment with different ways of stating the goals. Goal setting improves with practice, so play around with it.

Below are samples and templates for ECM Providers to individualize and tailor the ECM Care Plan for each member:

Diabetes:

Problem: Diabetes Program –Blood Glucose Monitoring

Goal	Member/caregiver/family will record the member's blood sugar levels at least 1 x daily for 30 days.
Intervention	The care manager will teach the member/caregiver/family how and why monitoring and logging blood sugar readings is vital.
Outcome	Member/caregiver/family will record blood sugar levels daily within 30 days.
Barrier	Member has trouble remembering to track blood sugar.

Problem: Diabetes Program –A1C Tracking

Goal	Member/caregiver/family will provide the healthcare provider with a record of the member's daily blood sugar levels in 30 days.
Intervention	The care manager will reinforce the importance of having a record of blood sugar levels for the healthcare provider.
Outcome	Member/caregiver/family provided healthcare provider a record of member's daily blood sugars within 30 days.
Barrier	Member has trouble remembering to track blood sugar.

Problem: Diabetes Program –A1C Tracking

Goal	Member's A1C level will be 7% or below in 90 days.
Intervention	The case manager will teach the member that the A1C test provides a picture of what their blood sugar levels have averaged over the last three months.
Intervention	The case manager will teach the member why it is essential to visit their doctor at least every three months to check their A1C level.
Intervention	The case manager will encourage the member to limit foods high in starchy carbohydrates, such as breads and pastas.
Intervention	The case manager will encourage the member to limit the intake of foods with added sugar, such as cookies, sodas, and syrup.
Intervention	The case manager will encourage the member to talk to their doctor on the next visit to discuss a safe exercise plan.
Outcome	Member's A1C level is 7% or below in 90 days.
Barrier	The member doesn't understand how to control her A1C

Problem: Diabetes –Diet and Nutrition Monitoring

Goal	Member will meet with a diabetic educator and/or dietician to learn about healthy, nutritious, and diabetic-appropriate food choices in compliance with recommended diet at least 1x within 30 days.
Intervention	The care manager will reinforce education regarding diet <*limiting sugar intake, reducing saturated/trans fats, avoiding cholesterol, reducing simple carbohydrates, increasing healthy carbohydrates, increasing fiber-rich foods, healthy heart fish, and good fats*>.
Outcome	Member engaged with diabetic educator and learned about healthy, nutritious, and diabetic-appropriate food choices in compliance with recommended diet in 30 days.
Barrier	The member doesn't understand how to control her A1C

Problem: Diabetes- Alcohol Use

Goal	Member/caregiver/family will identify two ways drinking alcohol can affect their diabetes in 30 days.
Intervention	The care manager will educate the member/caregiver/family on how alcohol may affect diabetes by interacting with some diabetic medications and causing severe side effects.

Intervention	The care manager will educate on how alcohol can impact blood sugar levels in the body and how the member feels throughout the day.
Intervention	The care manager will provide community resources for alcohol counseling if necessary.
Outcome	Member/caregiver/family repeats two ways alcohol consumption can affect diabetes within 30 days.

COPD:

Problem: COPD –Knowledge of the disease process

Goal	Member/caregiver/family will teach three (3) warning signs/symptoms of worsening COPD (Chronic Obstructive Pulmonary Disease) in 30 days.
Intervention	The care manager will teach member/caregiver/family signs/symptoms of worsening COPD, such as difficulty breathing when lying flat.
Intervention	The care Manager will teach member/caregiver/family the signs/symptoms of worsening COPD, such as coughing and wheezing more than usual with productive phlegm.
Intervention	The care Manager will teach member/caregiver/family the signs/symptoms of worsening COPD, such as increased shortness of breath when walking short distances.
Outcome	Member/caregiver/family can teach back three (3) warning signs/symptoms of worsening COPD within 30 days.
Barrier	Lack of information about COPD warning signs and symptoms

Problem: COPD- Knowledge of the disease process

Goal	Member/caregiver/family will obtain at least one educational resource on managing their COPD (Chronic Obstructive Pulmonary Disease) symptoms in the next 30 days.
Intervention	The care manager will educate the member/caregiver/family on signs/symptoms of COPD exacerbation and when to report early symptoms.
Intervention	The care manager will educate the member/caregiver/family on having all prescribed COPD medication handy at all times.
Intervention	The care manager will teach the member/caregiver/family when to contact the primary provider and/or specialist when symptoms worsen.
Intervention	The care manager will inform the member where the closest urgent care and emergency room is in the member's area.
Intervention	The care manager will educate the member/caregiver/family on when to use urgent care and emergency room appropriately.

Outcome	Member/caregiver/family received information and resources needed to manage their COPD symptoms within the last 30 days.
Barrier	Lack of information about COPD warning signs and symptoms

Chronic Pain:

Goal	Member will take the pain medication only as prescribed by her one designated prescriber.
Intervention	Care Manager will help the member develop a strategy in addition to medication adherence to reduce pain levels.
Intervention	Care Manager will help the member explore alternative pain management options with the primary care physician and or pain specialist.
Outcome	The member takes pain medication only as prescribed by her one designated prescriber.
Barrier	Member feels a lack of control over pain.

Depression:

Depression - triggers

Goal	Member/caregiver/family will be able to teach back at least two triggers that may increase depression symptoms within 30 days.
Intervention	Care Manager will review possible triggers with the member that may have caused or triggered an alteration in depression in the past.
Outcome	Member/caregiver/family teaches back at least two triggers that may increase depression symptoms within 30 days.
Barrier	Depressed mood.

Depression – lifestyle

Goal	Member will identify 1-3 activities that may help combat Depression in the next 30 days.
Intervention	Case Manager will review/explore activities that improve mood/combat depression, such as <*enter activities discussed with the member*>.
Intervention	Member will explore which activities improve mood such as <*enter activities discussed with the member*>.

Outcome	Member identified 1-3 activities that help combat depression in 30 days.
Barrier	Depressed mood

SUD (Specify in member's words or use dx if the member agrees):

SUD – counseling

Goal	Member will engage in a Substance use counseling program in the next 90 days.
Intervention	Case Manager will link the member with substance use counseling <*enter referral and resource info here*>.
Outcome	Member engages in substance use counseling in 90 days.
Barrier	SUD interfering with daily functioning.

SUD - Peer support

Goal	Member will attend a support group in the next 30 days.
Intervention	The case Manager will provide the member with a list of available support groups <*enter referral resources here*>.
Outcome	Member attended one peer support group in the next 30 days.
Barrier	Lack of sober support.

SUD – Harm Reduction

Goal	Member will teach back one action to reduce harm and risk associated with <*insert method and substance*> while not ready to abstain in 30 days.
Intervention	The case manager will encourage self-care and risk reduction while the member is not ready to abstain.
Outcome	Member teaches back one action to reduce harm and risk associated with <*insert method and substance*> while not ready to abstain in 30 days.
Barrier	Lack of Harm Reduction information and access

SUD – Meds/MAT

Goal	Member will take <*insert medication dose*> every <*insert frequency*> to treat substance use disorder in the next <*30/60*> days.
Intervention	Case manager will encourage adherence to Medication for Addiction Treatment (MAT).
Outcome	The member takes <insert medication dose> every <insert frequency> to treat substance use disorder in the last <*30/60*> days.
Barrier	SUD interferes with daily functioning.

Community-Based LTSS:

Member is at risk for needing institutionalization due to lack of community support.

Goal	Member will maintain community-based living with CBAS support x days per week.
Intervention	Care Manager will discuss with the member and PCP a referral to CBAS and help facilitate as appropriate.
Outcome Barrier	Member will maintain community-based living with CBAS support x days per week. Lack of community support

Member's capacity for self-care in the community is compromised due to frailty or disability.

Goal	Member will maintain community-based living with support from IHSS x hours per month.
Intervention	Care Manager will help the member apply for an IHSS evaluation.
Intervention	Member will cooperate with the IHSS evaluation process.
Outcome	Member will maintain community-based living with support from IHSS x hours per month.
Barrier	Needs help with Daily Living Activities

Housing Insecurity/Unhoused:

Member is currently unhoused

Goal	Member will attain income, vouchers, and/or benefits sufficient to pay for adequate housing for x number of people within 90 days.
Intervention	Care Manager will work with the members <Community Support> agency to help the member obtain housing.

Intervention	Member will attend necessary appointments related to housing.
Outcome	Member will attain income, vouchers, and/or benefits sufficient to pay for adequate housing for x number of people within 90 days.
Barrier	Member is unhoused.

Housing Insecurity

Goal	Member will reside in a desired, stable, housing code-compliant residence adequate to house X adults and x children within 90 days.
Intervention	Care Manager will work with member and member <Community Support agency> to restore or develop skills necessary to maintain housing.
Intervention	Member will attend necessary appointments related to housing.
Outcome	Member will reside in a desired, stable, housing code-compliant residence adequate to house X adults and x children within 90 days.
Barrier	Housing insecurity.

Overcrowded, substandard housing

Goal	Member will reside in a desired, stable, housing code-compliant residence adequate to house X adults and x children within 90 days.
Intervention	Care Manager will work with the members <Community Support> agency to help the member obtain housing,
Intervention	Member will attend necessary appointments related to housing.
Outcome	Member will reside in a desired, stable, housing code-compliant residence adequate to house X adults and x children within 90 days.
Barrier	Substandard housing.

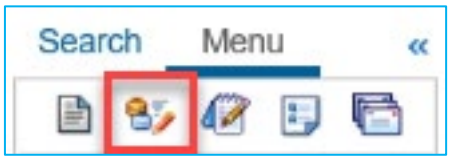
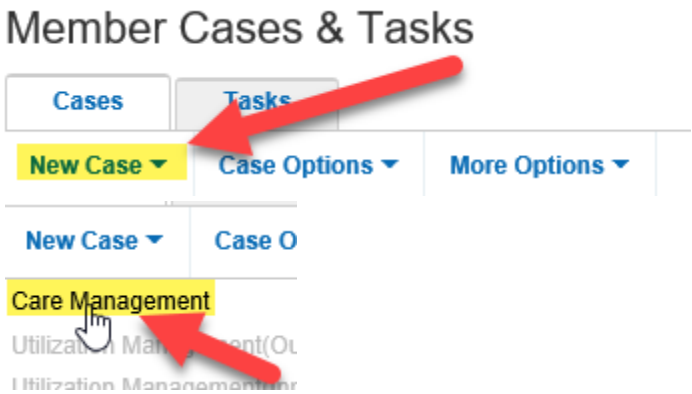
Unhoused and not ready to access housing

Goal	Member will access two services for basic needs (such as food, shower, and medical care) weekly for the next 30 days.
Intervention	Care Manager will link the member with (insert agencies, resources).

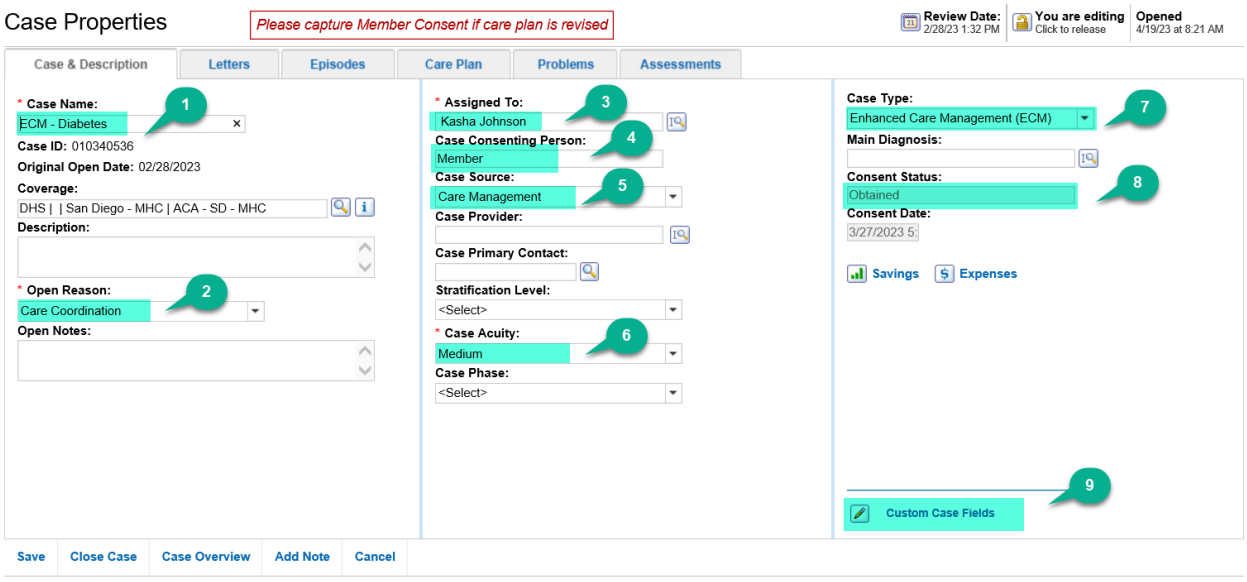
Outcome	Member will access two services for basic needs (such as food, shower, and medical care) weekly for 30 days.
Barrier	Unhoused, not ready for housing

Creating the Care Plan in CCA

Follow the steps below to create the member's care plan in CCA. Make sure you are assigned to the member in the Assignments section of CCA before opening a care plan:

INSTRUCTIONS	SCREENSHOT
Step 1: Start by accessing the Case Properties module. Select the briefcase icon.	
Step 2: To create a new care plan, select "**New Case**" and "**Care Management**." **Note:** Ensure you are assigned to the member. There should <u>only be one</u> ECM Care Plan per Member. The member can have multiple problems listed under one care plan.	

Step 3: The **Case Properties** tab will appear. Fill in the following areas in green:

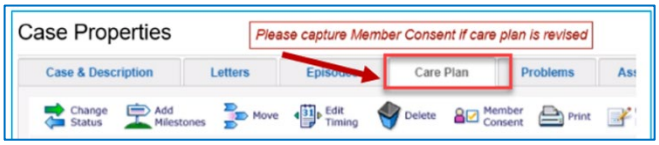


FIELD NAME	INSTRUCTIONS
1. Case Name *Mandatory field*	Enter name that describes the case, typically the member's main health concern. All Case Names should start with "**ECM**-" followed by a hyphen and then the main health concern. Ex. ECM-Asthma
Coverage	No action is needed.
Description	Leave blank.
2. Open Reason *Mandatory field*	Select **Care Coordination** as the reason from the drop-down. *Note:* This can't be changed after saving.
Open Notes	No action is needed.
3. Assigned To	Auto-populates to the case manager creating the case. Check that the ECM LCM assigned to the member populates here.
4. Case Consenting Person *Mandatory field*	Enter the name of the person agreeing to the ECM Care Plan (may enter 'Member' if agreeing to the care plan)
5. Case Source *Mandatory field*	Choose **Care Management** from the drop-down.
Case Provider	No action is needed.
Case Primary Contact	No action is needed.
Stratification Level	Leave blank.
6. Case Acuity *Mandatory field*	Indicate the risk level for the member (**Medium, High, Catastrophic**). Refer to the *Case Acuity* section for detailed definitions. (Members with Low acuity should not be enrolled in the Program. If any members have a "Low" acuity, they should be evaluated to determine if they are well managed or continue to meet the eligibility for Enhanced Care Management).
Case Phase	Leave blank.
7. Case Type *Mandatory field*	**Enhanced Care Management Program (ECM)** Do not leave this field blank. Select *Enhanced Care Management Program (ECM)* from the drop-down.
Main Diagnosis	Leave blank.
8. Consent Status *Mandatory field*	Consent status must equal "Obtained." This is selected under the Care Plan Tab. If "Obtained" is not selected within 90 days of enrollment, the Care Plan is considered non-compliant, even if it was created on time. Also, the ECM LCM is required to capture member consent every time the care plan is revised.
9. Custom Case Fields *Mandatory field*	Click on the icon in the lower right-hand corner. A dialogue box for Case Category will appear. Select the condition that most closely corresponds with the case name/diagnosis. If a condition cannot be identified, select **Other**.

FIELD NAME	INSTRUCTIONS
Save	Click save to create the case.

The care plan needs to contain the Guidelines and Milestones associated with a member's existing cases. Guidelines are a standard set of goals and milestones reflecting the best practices for managing a particular problem or diagnosis.

The **Care Plan** tab allows the user to manage Guidelines, Milestones, Tasks, and Goals associated with a member's Problem.



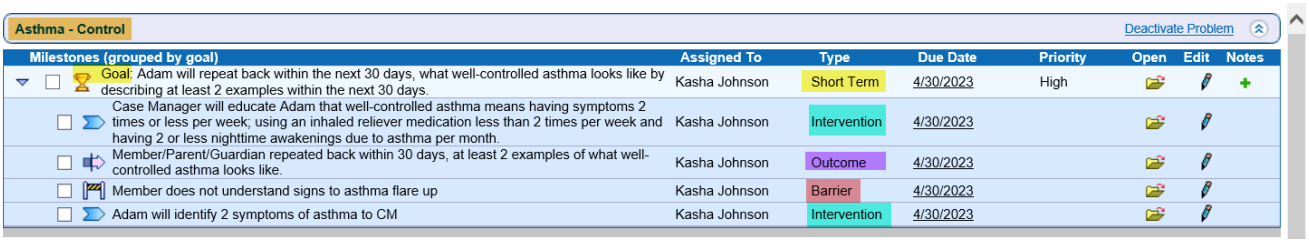
How to Review the Care Plan

Milestones

Icon	Type	Description
	Barrier	A condition or event that may delay or prevent reaching the plan goals
	Goal	The state or activity to be achieved by the plan, solving or alleviating the defined problem.
	Intervention	An activity or step that needs to be taken to achieve the specified goal
	Member Interaction	A milestone who's content will be communicated to the member on due date
	Not Associated (Tree View)	Denotes milestones added to the plan but not associated with a goal (using the Move function)
	Other	A milestone used for any purpose other than problem, goal, intervention, barrier and outcome.
	Outcome	Outcome - A measurement of progress the patient should reach in achieving the specified goal
	Reference	Reference - A milestone that is used as a placeholder for information for the care manager

- Lets you see each item's status
  - Objective met.
  - Objective partially met.
  - Objective not met.
  - Objective past the due date.
  - N/A Objective not applicable
- Objective's Task silenced.
- Lets you see if each goal is shareable.
  - Shareable
  - Not shareable

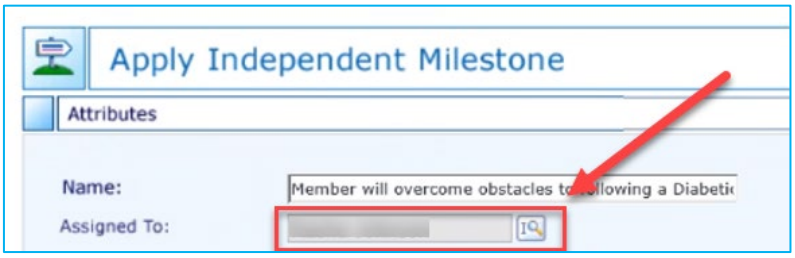
Note: The icons above are always listed under the Problem. See the example below:



Layout of how to create the Care Plan:

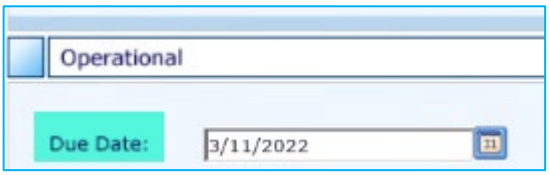
Milestones – The individual components in a guideline (Goal, Intervention, Outcome, Barriers, etc.)

Assigned To – Person who works the case

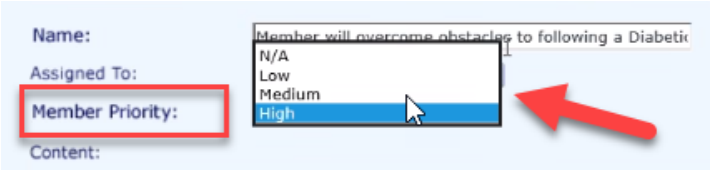


Type – Long-Term or Short-Term

Due Date – Date a task or review is due



Priority – see the steps below to enter/edit a Priority



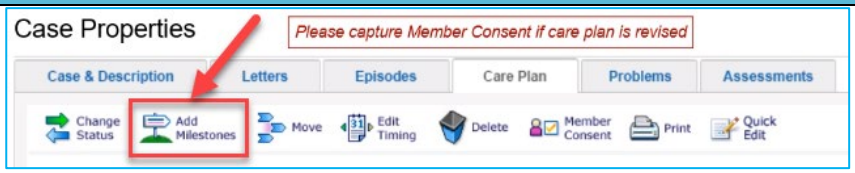
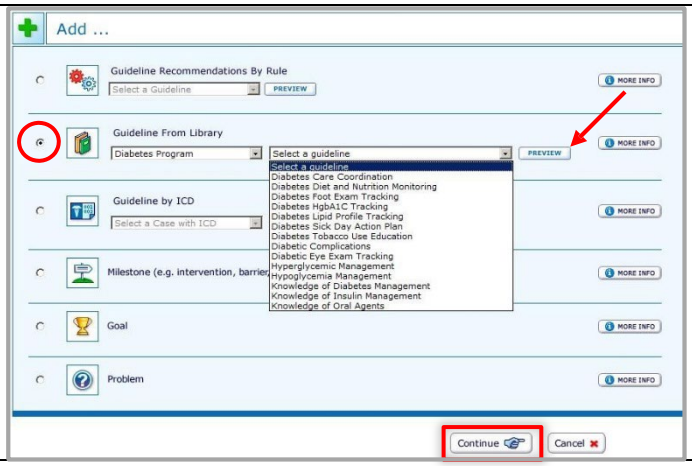
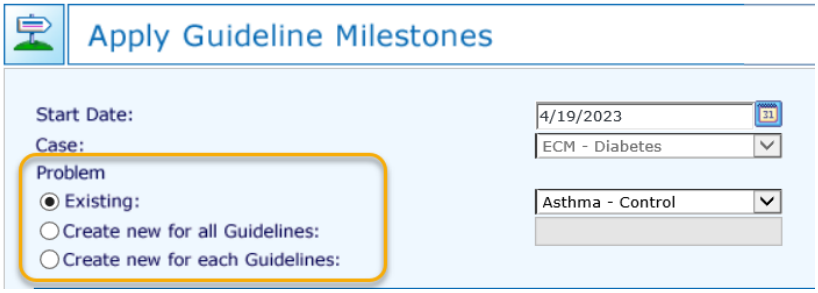
The following sections will show two different ways of creating a care plan; one is through the library, and the other is Individualized:

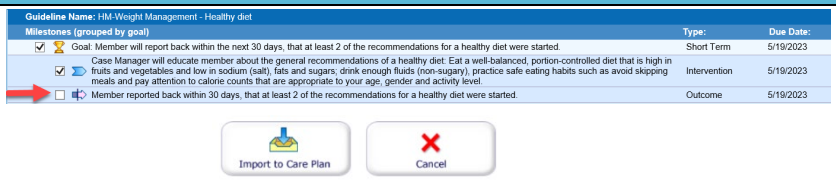
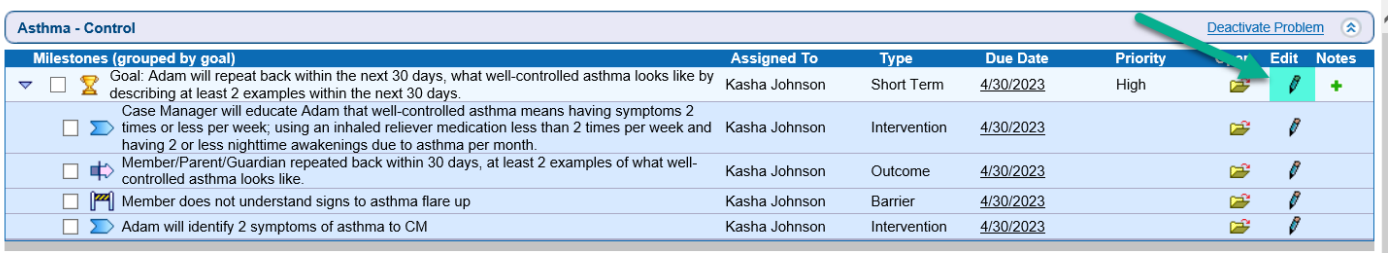
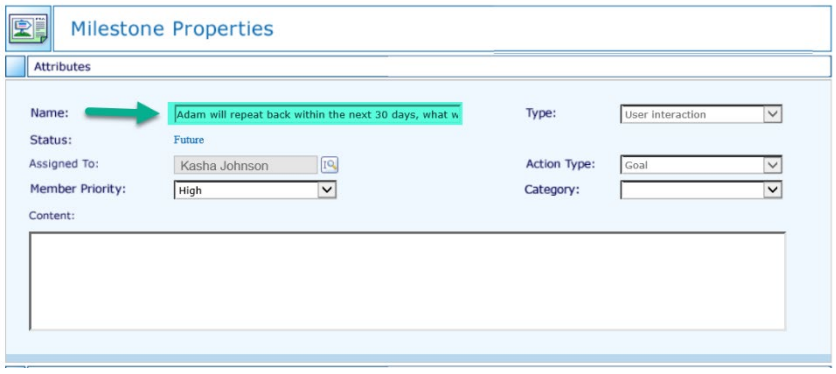
How to Create a Standard Milestone from the Library

This section outlines adding milestones/goals using the **Library Guidelines**. These are "standard" milestones/goals since they are selected from the library. **Milestones and goals must be unique to the member and individualized**.

The Case Name from case creation becomes the member's first problem banner within the care plan.

Follow the steps below to add a standard milestone/goal:

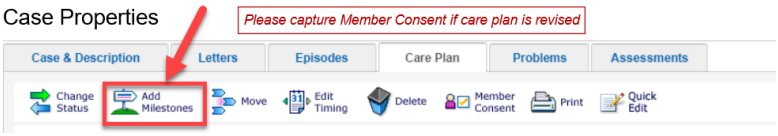
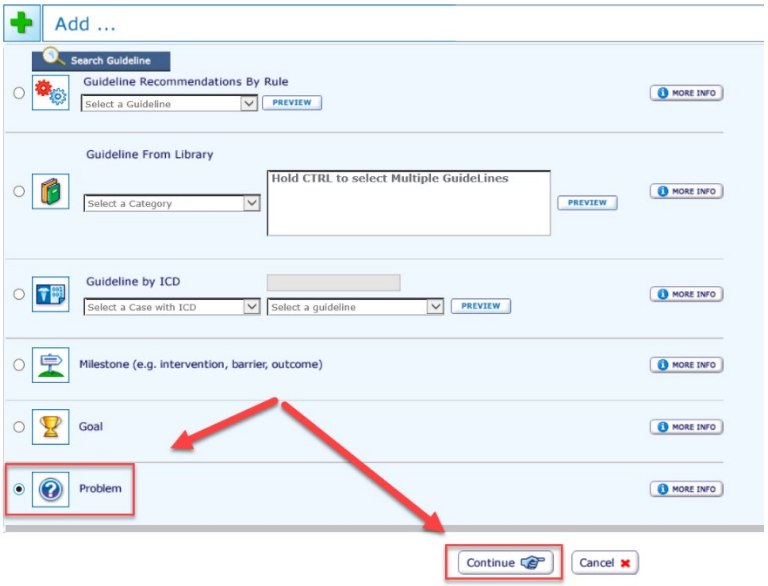
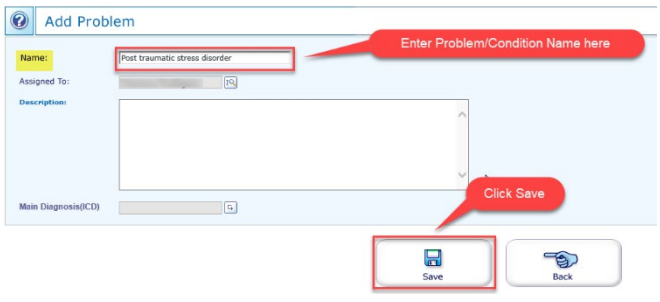
INSTRUCTIONS	SCREENSHOT
Step 1: On the **Care Plan** tab, click **Add Milestones**.	
Step 2: Select the radio button next to Guideline from Library on the Add page. Then, select the appropriate category from the **Category** drop-down. Followed by choosing the appropriate guideline from the Guideline drop-down. **Preview** lets you preview the category and guidelines before importing them into the care plan. On the Add page, click **Continue.**	
Step 3: The **Apply Guidelines Milestone** page is displayed. **Problem:** a. Select **Existing** if adding to a problem *already created* in the care plan; select problem from the drop-down menu. **CCA defaults to the Create New radio button.** b. Select **Create New** if creating a new problem within the care plan. Can edit the title of the problem here if desired.	

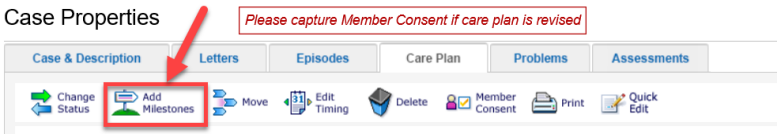
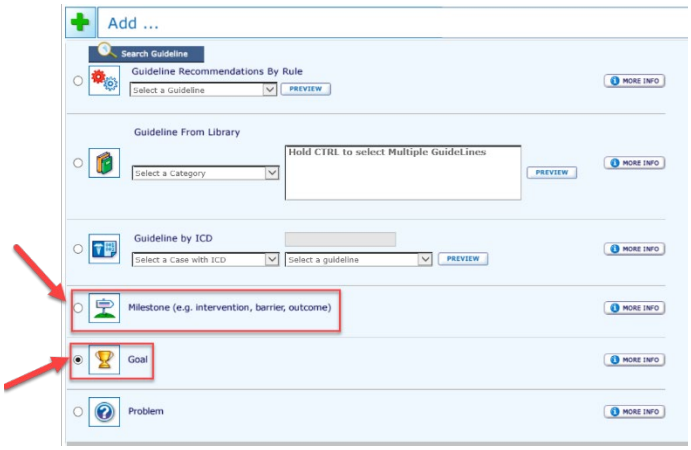
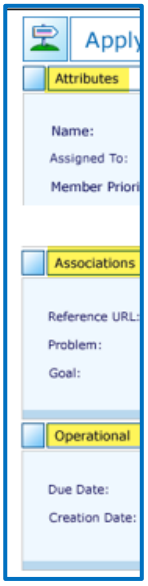
INSTRUCTIONS	SCREENSHOT
Step 4: **Uncheck** anything you do *not* want to import into the care plan. **Step 5:** Click **Import to Care Plan** Users need to go back to the **Care Plan** tab and add **additional/new** milestones/goals (e.g., barriers, self-management activities, etc.) to build the member's care plan. *Refer to the care plan guidelines mentioned previously.*	
Step 6: Customize Milestones. The system is set up to create efficiencies to help the member meet health and personal goals; however, you will need to incorporate individualized language. Milestones from the Library Guidelines can be customized using the *Milestone Properties* page. **In order to make the custom care planning process the easiest, enter in the following order problem, goal, intervention, and barrier, and complete one milestone set at a time.** Follow the steps below to customize milestones using the *Milestone Properties* page: Click the pencil icon under "Edit" on the Care Plan tab at the level you wish to modify.	
Step 7: On the **Milestone Properties** page, modify the **name** of the goal, intervention, barrier, or outcome. **Follow steps 11-14 under "Adding an Individualized Milestone Guideline" below to complete the Attributes, Associations, and Operational sections within the Milestone Properties.** **Follow the steps under "Prioritizing Goals" to prioritize the goal(s)**	
Step 8: Click **Update**	

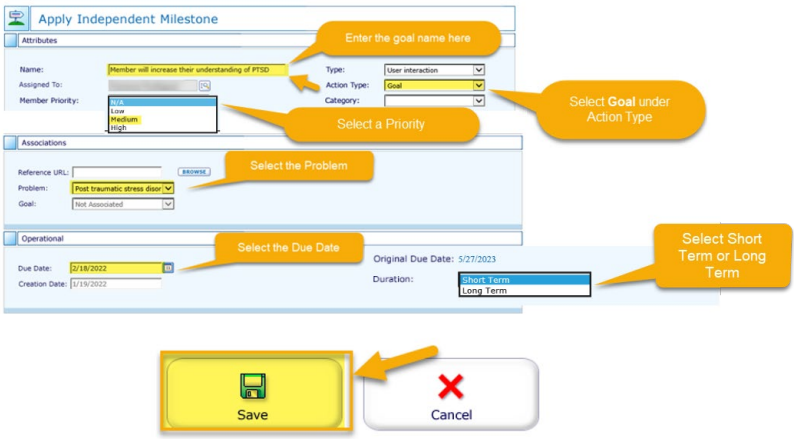
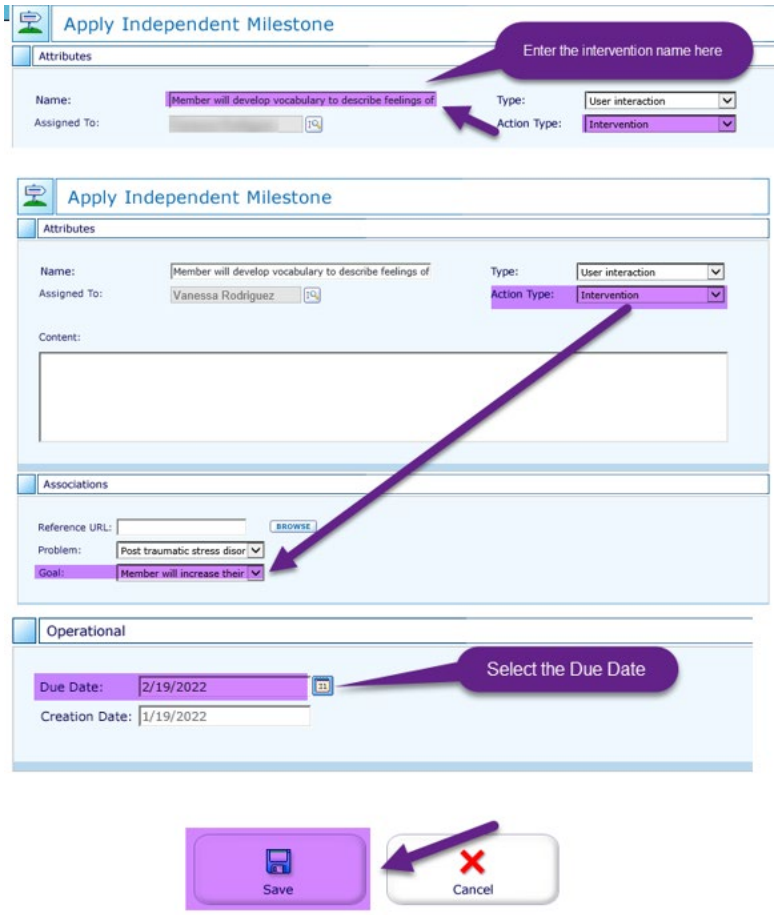
Adding an Individualized Milestone Guideline

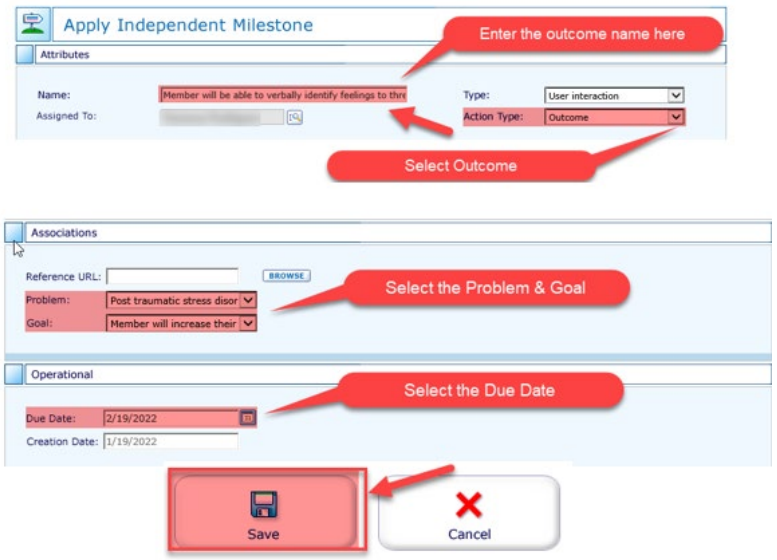
Problems and milestones that are NOT listed in the Library Guidelines can be created **independently**. It is necessary to individualize the member's goals by editing Library Guidelines or creating customized milestones. Personal goals are typically added using this process.

Follow the steps below to add an independent problem (not listed in the Library Guidelines):

INSTRUCTIONS	SCREENSHOT
Step 1: Click **Add Milestones** icon	
Step 2: On the **Add** page, select the radio button next to **Problem** to create a new gray bar/problem	
Step 3: Click **Continue**	
Step 4: Enter the Problem / Condition Name in the new window. **Note:* No description needed – leave blank.*	
Step 5: Click **Save**	

INSTRUCTIONS	SCREENSHOT
Step 6: Attaching Individualized Milestones/Goals to a Problem. Once the problem has been created, users are then able to attach milestone(s) to the problem. A milestone may include one or more goals, interventions, and outcomes. To do so, follow the process below. Click **Add Milestones** icon.	
Step 7: The **Add...** page displays	
Step 8: Select the radio button next to **Goal or Milestone.**	
Step 9: Click **Continue.**	
Step 10: The **Apply Independent Milestones** page displays. The following sections will need to be completed: • Attributes • Associations • Operational	

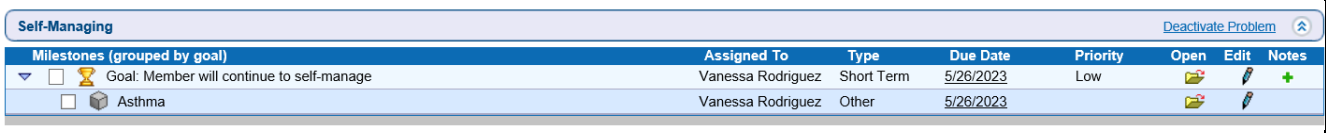
INSTRUCTIONS	SCREENSHOT
Step 11: Creating Goals Under the **Attributes** section, select *Goal* under **Action Type.** Enter the goal name under the **Name** section. Select a priority under **Member Priority**. Under the **Associations** section, select the **Problem**. Lastly, under the **Operational** section, select the **Due Date**. Click **Save**	
Step 12: Creating Interventions Under the **Attributes** section, select **Intervention.** Enter the Intervention name under the **Name** section. ***Note:*** When the "Action Type" is an Intervention, ALWAYS associate the intervention with the appropriate goal Under the **Operational** section, select the **Due Date**. Click **Save**	

INSTRUCTIONS	SCREENSHOT
Step 13: Creating Outcomes Under the **Attributes** section, select **Outcome.** Enter the Outcome's name under the **Name** section. Under the **Associations** section, select the **Problem & Goal**. Under the **Operational** section, select the **Due Date**. Click **Save**	
Step 14: Creating Barriers Under the **Attributes** section, select **Barrier.** Enter the Outcome's name under the **Name** section. Under the **Associations** section, select the **Problem & Goal**. Under the **Operational** section, select the **Due Date**. Click **Save**	

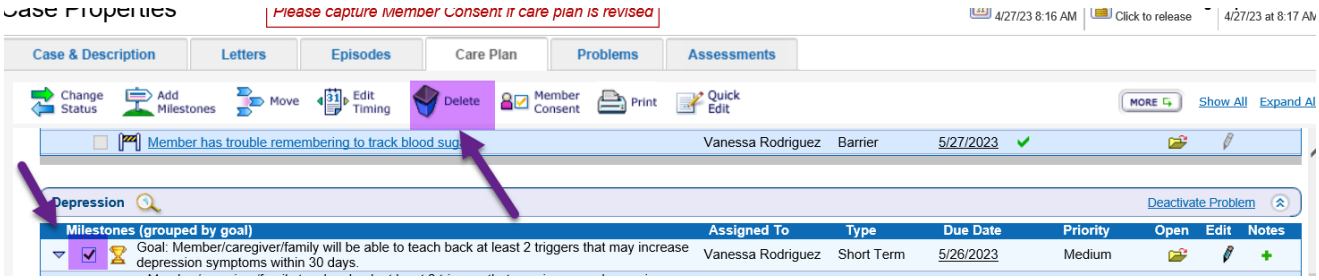
INSTRUCTIONS	SCREENSHOT

Step 15: Self-Management Goals

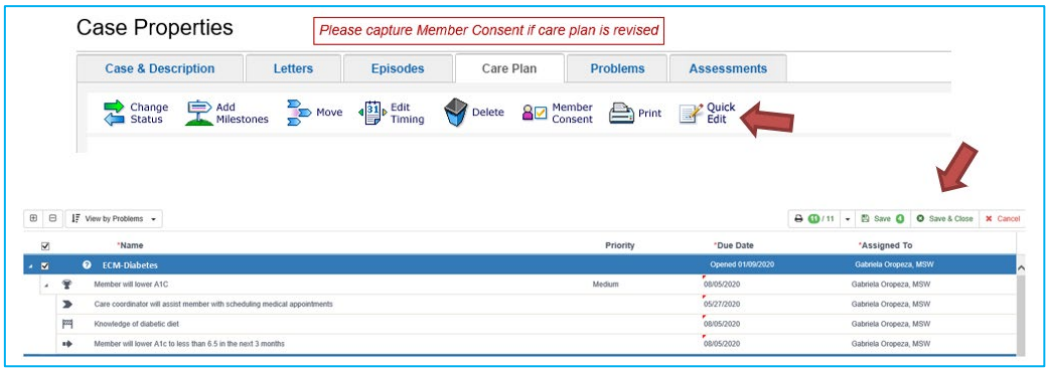
For problems/concerns that the member is self-managing, enter a problem (follow the regular steps above) and name the problem **"Self-Managing."** Enter a goal and name it **"Member will continue to self-manage,"** along with a **due date** and a **priority.** Enter the self-managing problem/concern (individually) as **"Other" (under Action Type) and add a due date. See the example below:**



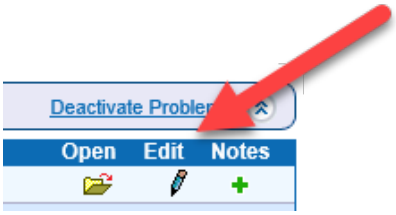
Step 16: To delete a milestone, check off the milestone you wish to delete and then select **Delete:**



To edit milestones, select **Quick Edit.** The following will appear. You can edit the milestones and then select **Save & Close.**



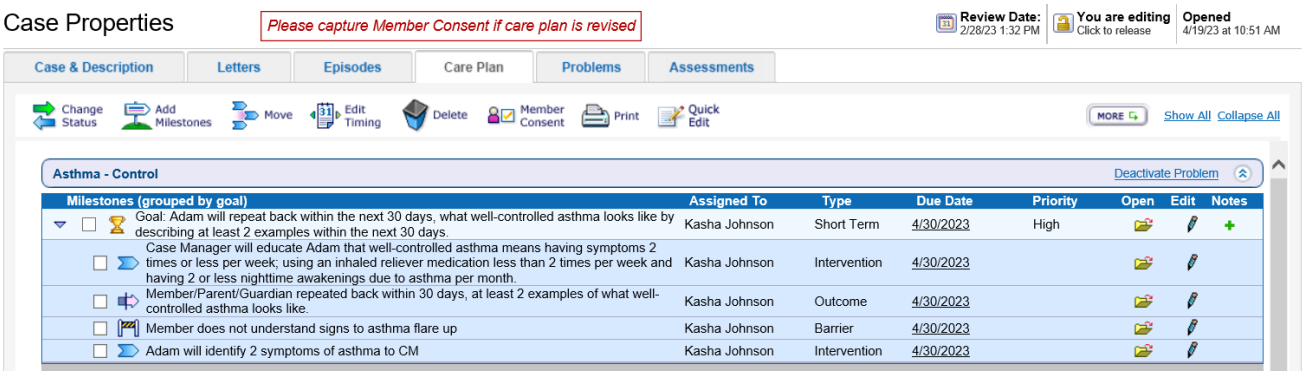
You can also edit the milestones by selecting **Edit:**



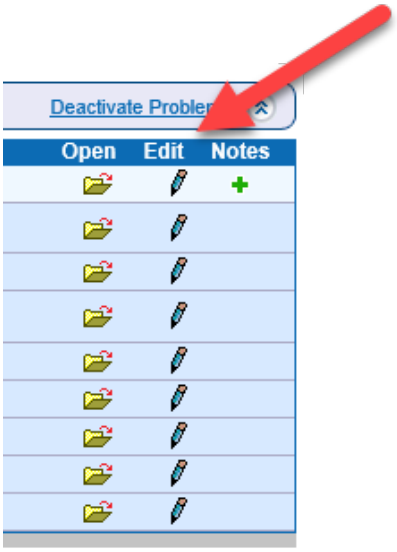
Prioritizing Goals

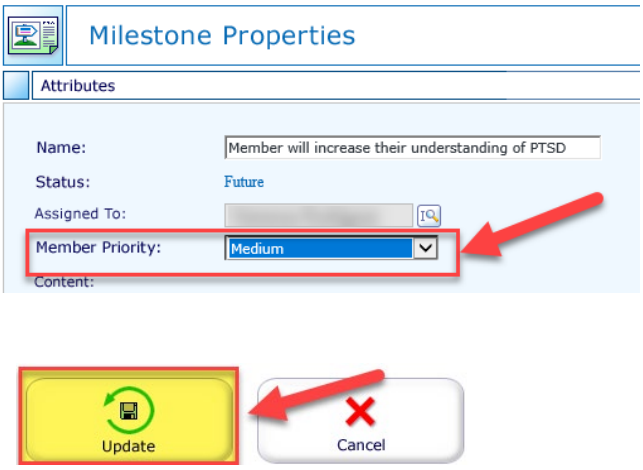
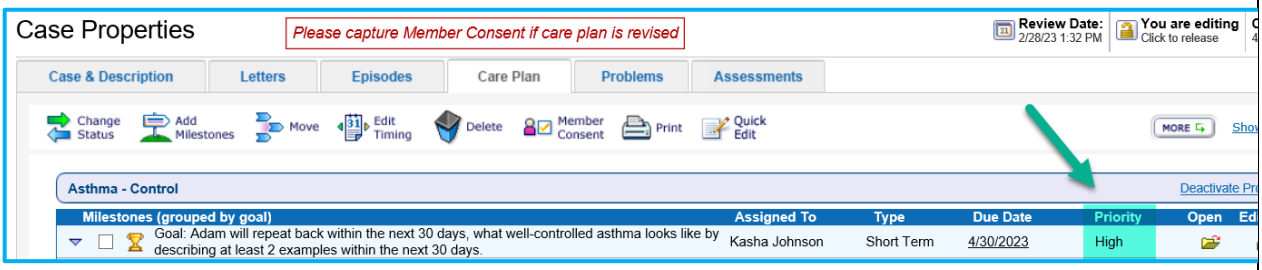
When completing the CA HRA and/or comprehensive assessment, document the member's stated goals and prioritize the level (low, medium, or high) with the member. It is required to prioritize the goals within the care plan.

The **Care Plan** tab is shown in the following image:



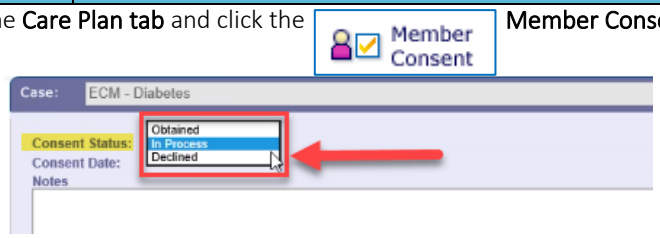
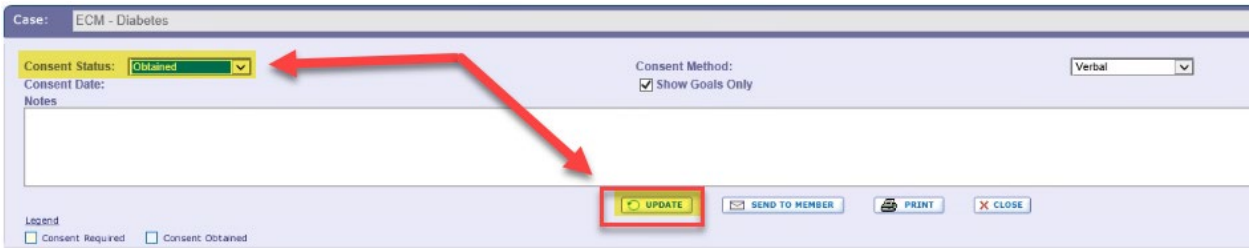
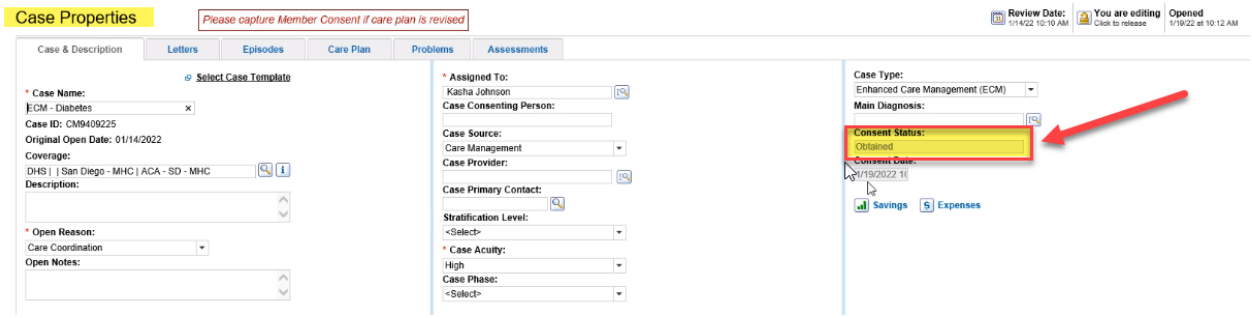
Follow the steps below to edit the goal priority:

INSTRUCTIONS	SCREENSHOT
Step 1: On the **Care Plan** tab, click the pencil icon under "Edit" of the selected goal	
Step 2: On the **Milestone Properties** page, locate the **Attributes** section	

INSTRUCTIONS	SCREENSHOT
Step 3: Select the appropriate option (Low, Medium, or High) from the drop-down in the Member Priority field. Click **Update**	
Step 4: The updated priority displays in the Priority field	

Obtaining Member Consent

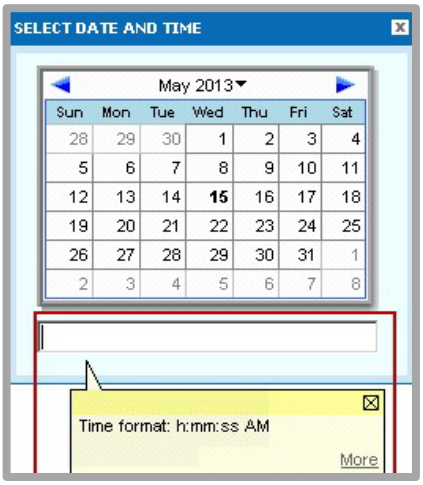
Once the care plan has been developed with the member (or member's representative), consent must be obtained. Member consent means the ECM LCM discussed the care plan with the member (or member's representative) and agreed with the care goals and any care plan updates. If "Obtained" is not selected within 90 days of enrollment, the Care Plan is considered non-compliant, even if it was created on time. Follow the steps below to change the **Consent Status** to "**Obtained**."

INSTRUCTIONS	SCREENSHOT
Step 1: To open the **Member Consent Page,** click the **Care Plan tab** and click the **Member Consent** toolbar button. The **Member Consent Page** will appear, click on the drop-down **for Consent Status** and change it from **In Process** to **Obtained** and select **UPDATE** at the bottom and then select **CLOSE**	 
Step 2: Open the **Case Properties** and ensure the **Consent Status** section says **"Obtained"**:	

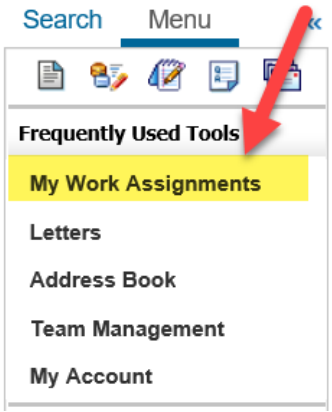
Note: Anytime the care plan is revised, *Steps 1-2* **MUST** be repeated.

Review Date

The Review Date is system generated, but the ECM LCM is recommended to select a personal Next Review for cases manually. Follow the steps below to select a personal Review Next date manually:

INSTRUCTIONS	SCREENSHOT
Step 1: Click on the **Review Date** icon.	
Step 2: Select the Personal Review Date for the care plan using the calendar.	
Step 3: Type the time according to the format in the dialog box and click **Select**.	

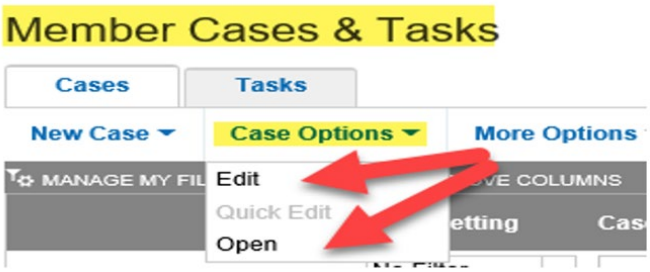
Step 4: Open **My Work Assignments**:



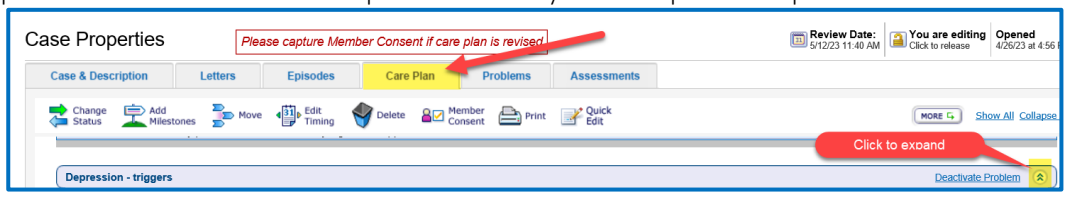
Click on the **CM** tab to confirm the Next Review Date.

Care Plan Updates

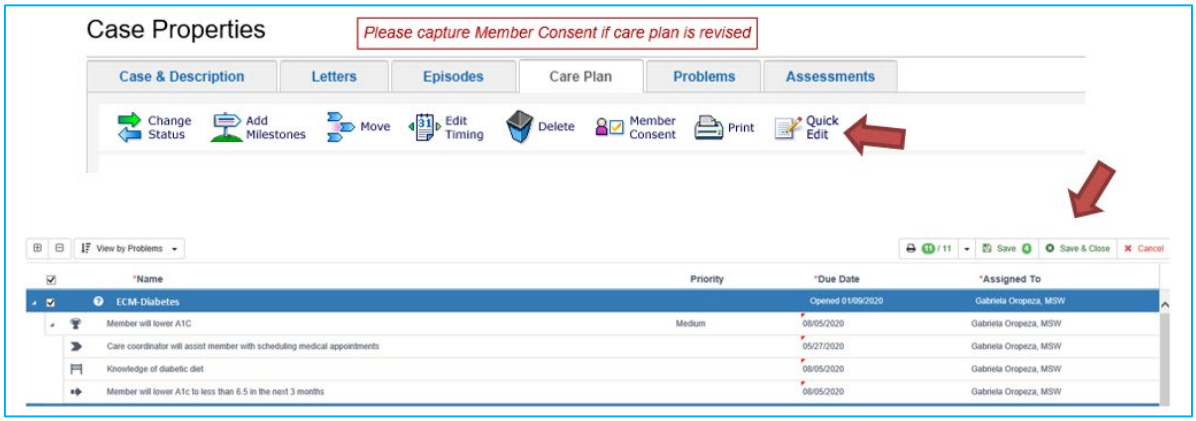
The care plan should consistently be updated at a frequency appropriate for the member, especially when there is a change in condition, upon reassessment, care conference, and/or care plan progress updates; however, no later than six months from the last care plan update. Follow the steps below to update the care plan:

INSTRUCTIONS	SCREENSHOT
Step 1: To view the current care plan, go to the  icon. Select the ECM care plan (to bring it into focus) and select "**Open**" under "**Case Options**." To make edits to the care plan, select **"Edit."**	

Step 2: Expand the PGIOBs to view the care plan in its entirety and edit specific components:



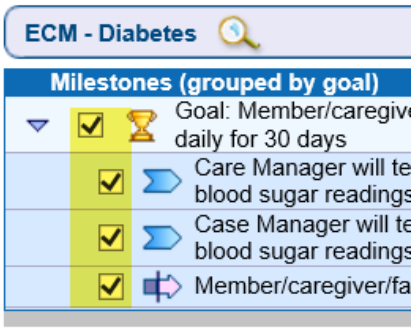
You can also use the "Quick Edit" option to make updates.



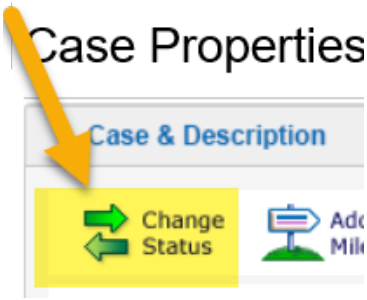
Once the care plan is open, follow the steps listed above, as needed, for each section being updated

INSTRUCTIONS	SCREENSHOT

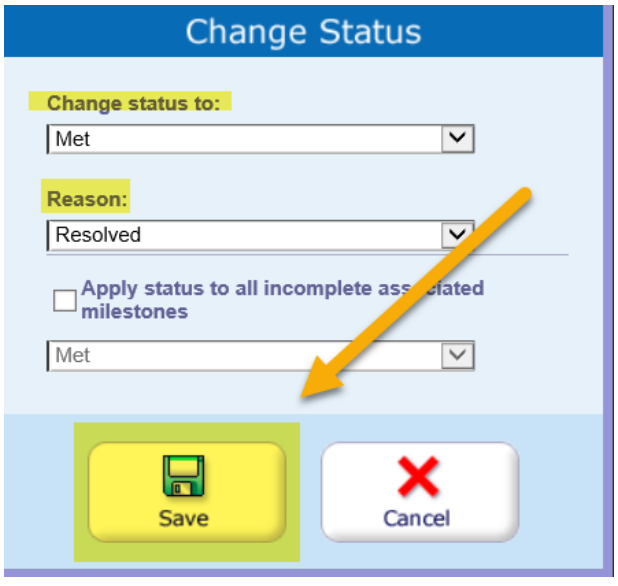
Step 3: To change the status of the milestones, check off the milestones you want to change the status to:



Select the **"Change Status"** icon.

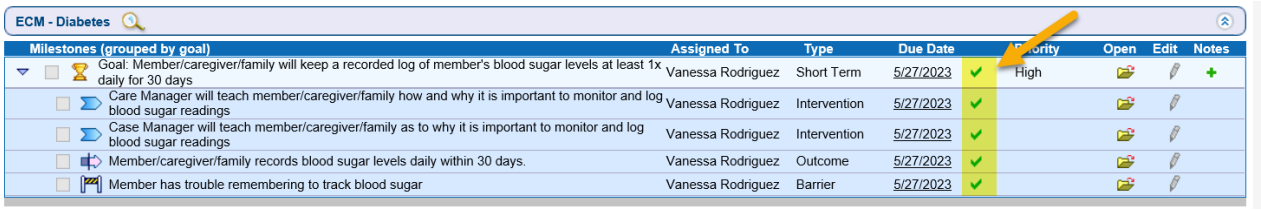


A **"Change Status"** window will appear. Select the appropriate change status and Reason, then click Save:



The change status will reflect those milestones that were selected. See the example below:

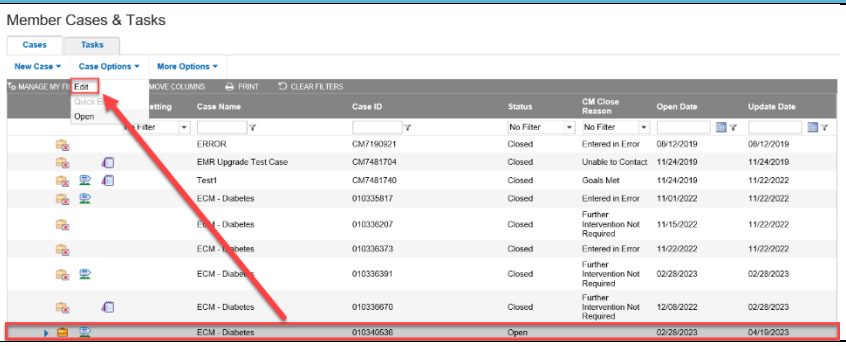
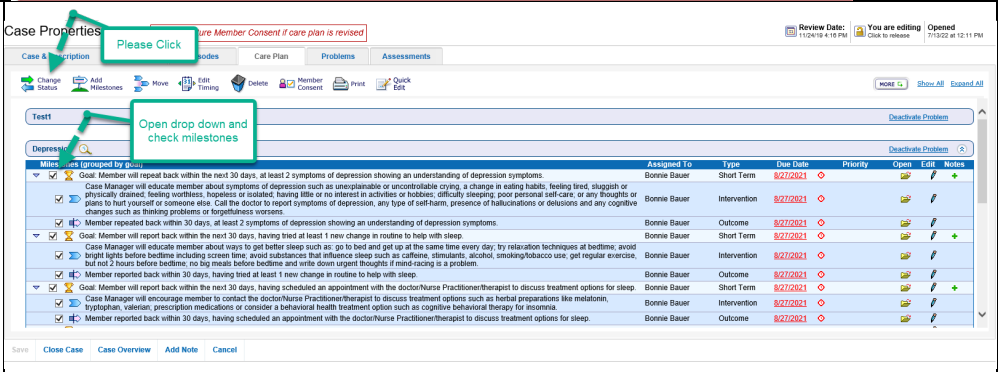
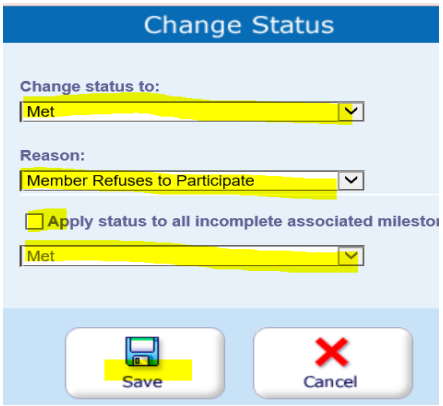
INSTRUCTIONS	SCREENSHOT

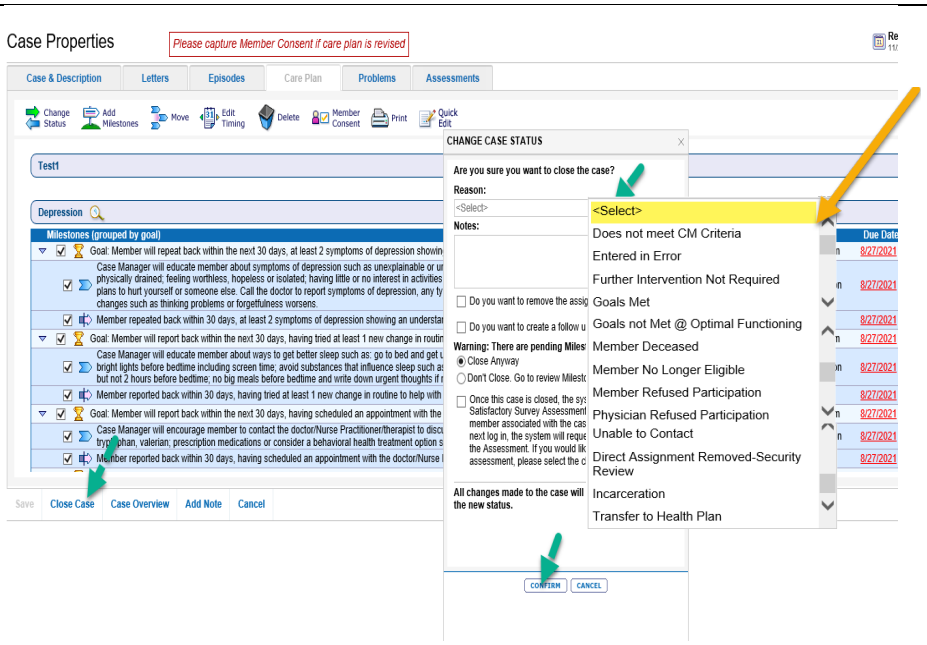


Step 4: Follow the steps under "**Obtaining Member Consent**"

Closing the Milestones and Care Plan

Prior to disenrolling a member, the ECM LCM is required to close the care plan and all milestones. Follow the steps below to close the care plan and all milestones:

INSTRUCTIONS	SCREENSHOT
Step 1: Select the care plan you want to close and click **Edit** under the **Case Options**	
Step 2: Select the **Care Plan** tab. Click on the **Change Status** section, expand the problems, and **check all the milestones (if they are not all checked, it will only close the one that was checked off)**. This will clear out all the due dates in **red**.	
Step 3: Change Status will depend on the reason why the ECM LCM is closing the care plan **Change the status to:** *** Met * Not Met** **Reason:** *Member Refuses to Participate *No Longer Applicable *Not Resolved *Resolved *Unable to Contact Click the ***Apply Status to all Incomplete associated milestones*** **Second drop Down:** *** Met * Not Met**	

INSTRUCTIONS	SCREENSHOT
Then click **Save**	
Step 4: Closing the care plan Under the **Care Plan** tab, select **Close Case.** A window will appear. Click the drop-down under **Reason** and select why you are closing the care plan. Under **"Warning: There are pending Milestones you may want to,"** select **Close Anyway** and click **Confirm.**	

Case Conferences

The purpose of the Case Conference is to help ensure that the member's care is continuous and integrated among all service providers. The role of the interdisciplinary care team is to provide input to both the development and the ongoing maintenance of the member's care plan.

Who coordinates the ECM Case Conference?

- The ECM Lead Care Manager

Who is required to participate?

- ECM Lead Care Manager
- ECM Director
- ECM Clinical Consultant
- ECM Community Health Worker
- Housing Specialist (as needed)

Who can also be invited based on the member's needs/preferences?

- ECM Provider Subject Matter Experts as applicable
- Pharmacist
- Nutritionist
- Caregiver
- PCP/Specialists
- Behavioral Health Providers
- MedZed HC 2.0 care coordinator (if the member is enrolled in this program)
- My Care Palliative Care (if member enrolled is enrolled in this program)
- Major Organ Transplant (if member enrolled is enrolled in this program)

What members should be presented in a Case Conference?

- All ECM members have high and catastrophic acuity based on Molina's Case Management Acuity.
- Members who are homeless and authorized to receive Housing Community Supports
- Any members who request a case conference. Molina has this question in the CA-HRA. A case conference meeting needs to happen within 60 days of the CA-HRA completion date. If no ICT was requested, there still needs to be evidence of ongoing information sharing among the member's multidisciplinary care team.
- Members should also be present if the ECM Lead Care Manager needs help with the care plan or is having difficulty implementing the goals of the care plan.
- Members with recent ED visits or hospitalization (including skilled nursing facility stays) should be reviewed, and the care plan should be updated based on changes in condition or housing status.
- Members with safety concerns, unmet BH/SUD, and/or APS/CPS reports

Timeframes to present cases in Case Conference

- Within 60 days of identified need, dependent on the acuity of the situation

How is it documented?

- All Case Conferences must be documented via a Contact Form in CCA. Documentation should include the following:
    - Names of all case conference attendees (titles and relationship to member)

- Notes on the outcome of the ICT meeting. Evidence that case conference recommendations were discussed with the member and incorporated into the care plan as applicable.
- Evidence that meeting details were shared with all case conference members

Follow up after Case Conference

- The ECM Care Plan must be updated based on case conference recommendations
- Updated ECM Care Plan must be shared with the member, PCP, and other members of the care team as appropriate

Case Conferences- Contact Forms

Below is an example of how to document an ICT meeting via a contact form in CCA:

Scenario #1: Post-enrollment. Member approved for Community Support Service. ECM LCM conducted an ICT meeting with the member's CS Provider. *Note: If a CS Provider already entered a contact form evidencing the ICT meeting with the ECM Provider, the ECM Provider is not required to do this again.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider ICT with CS Provider 4/25/23
Contact Type	Interdisciplinary Care Team
Contact Date	04/25/2023
Contact Method	Phone
Contact Method Other	
Contact Direction*	Outbound
Respondent*	ECM Provider
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM ICT Meeting
Purpose Of Contact Other	
Outcome Of Contact	Successful Contact
Outcome Of Contact Other	
Length Of Contact	30
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/25/23, I met with the member's CS Provider, Hilda Chavez, from Care #1, and we held an ICT meeting to discuss the member's current care. Care plan will need to be updated. I will discuss care plan updates with the member and get the member's consent during our next meeting. I provided an ICT meeting summary to Hilda Chavez, CS Provider, and agreed to meet in a month from today for another ICT meeting.

Clinical Consultant Reviews

Each ECM provider is required to have a Clinical Consultant on their care team to oversee the clinical aspects of the program. The Clinical Consultant should review the CA-HRA, care plan, and additional assessments, participate in ICT meetings, and provide input during these conversations as needed. Clinical reviews need to occur on a recurring basis (e.g., when ECM LCM is updating the care plan due to the member's change in condition or providing input during ICTs, etc.) and be documented via a contact form in CCA by either the Clinical Consultant or the ECM LCM, who can document on behalf of the Clinical Consultant. The ECM LCM is responsible for coordinating these ICT meetings.

This individual is responsible for the following:

- Ensuring clinical assessment elements leading to the creation of the plan of care are under the direction of an independently licensed clinician.
- Review documentation and provide input as needed.
- Acting as the clinical resource for your team as needed.
- Assist with care coordination for members as needed.

This role must be filled by an independently licensed clinician who may be a primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed behavioral health care professional, social worker, or other licensed behavioral health care professional. The licensure for your clinical consultant must be an active license in good standing in California.

Clinical Consultant Reviews- Contact Forms

Clinical consultant reviews must be documented via a Contact Form in CCA. The ECM LCM can document on behalf of the Clinical Consultant. Documentation of Clinical Consultant name, credentials, and review and input of the HRA and ICP (if the ECM LCM holds an appropriate clinical license, no clinical consultant review is required). Each HRA, assessment, ICP, or ICT meeting must include documentation of the review/input of the Clinical Consultant.

- Contact Type: Interdisciplinary Care Team
- Contact Date: Date clinical review occurred
- Contact Method: Select the appropriate contact method
- Contact Direction: Outbound
- Respondent: ECM Provider
- HIPAA Identity/Authority Verification: Member ID, DOB or Address, DOB or Member ID, Address
- Purpose of Contact: ICT Meeting, ECM, (any other valid service like Care Plan Development/ Revision if discussing care plan)
- The Outcome of Contact: Successful Contact
- Length of Contact: Time it took to complete the clinical review

Include in the contact form notes section the name of the Clinical Consultant who conducted the review, their credentials, and the outcome of the clinical review.

Below is an example of how to complete a Contact Form in CCA:

Scenario #1: Post-enrollment. ECM LCM presented the member's care plan to their Clinical Consultant. The Clinical Consultant reviewed the care plan.

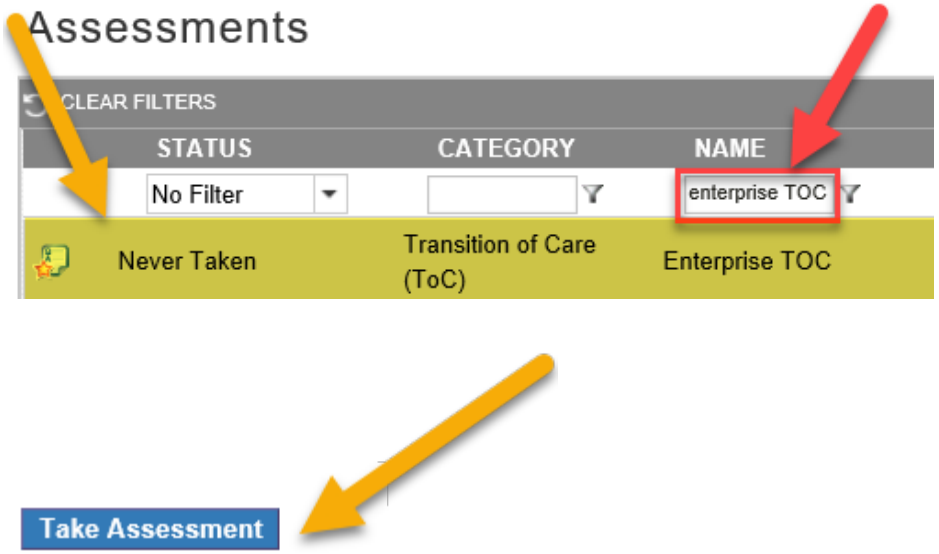
Contact Form Fields	How to Complete the Contact Form Fields
Subject	ECM Program - Best ECM Provider Clinical Consultant Review 4/10/23
Contact Type	Interdisciplinary Care Team
Contact Date	04/10/2023
Contact Method	Phone
Contact Method Other	
Contact Direction	Outbound
Respondent	ECM Provider
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Care Plan Development/ Revision ICT Meeting
Purpose Of Contact Other	
Outcome Of Contact	Successful Contact
Outcome Of Contact Other	
Length Of Contact	45
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/10/23, I presented the care plan to our clinical consultant, Nadine Khan, RN. Nadine reviewed the care plan and had no additional feedback to provide. I will meet again with Nadine to discuss the member's progress next month.

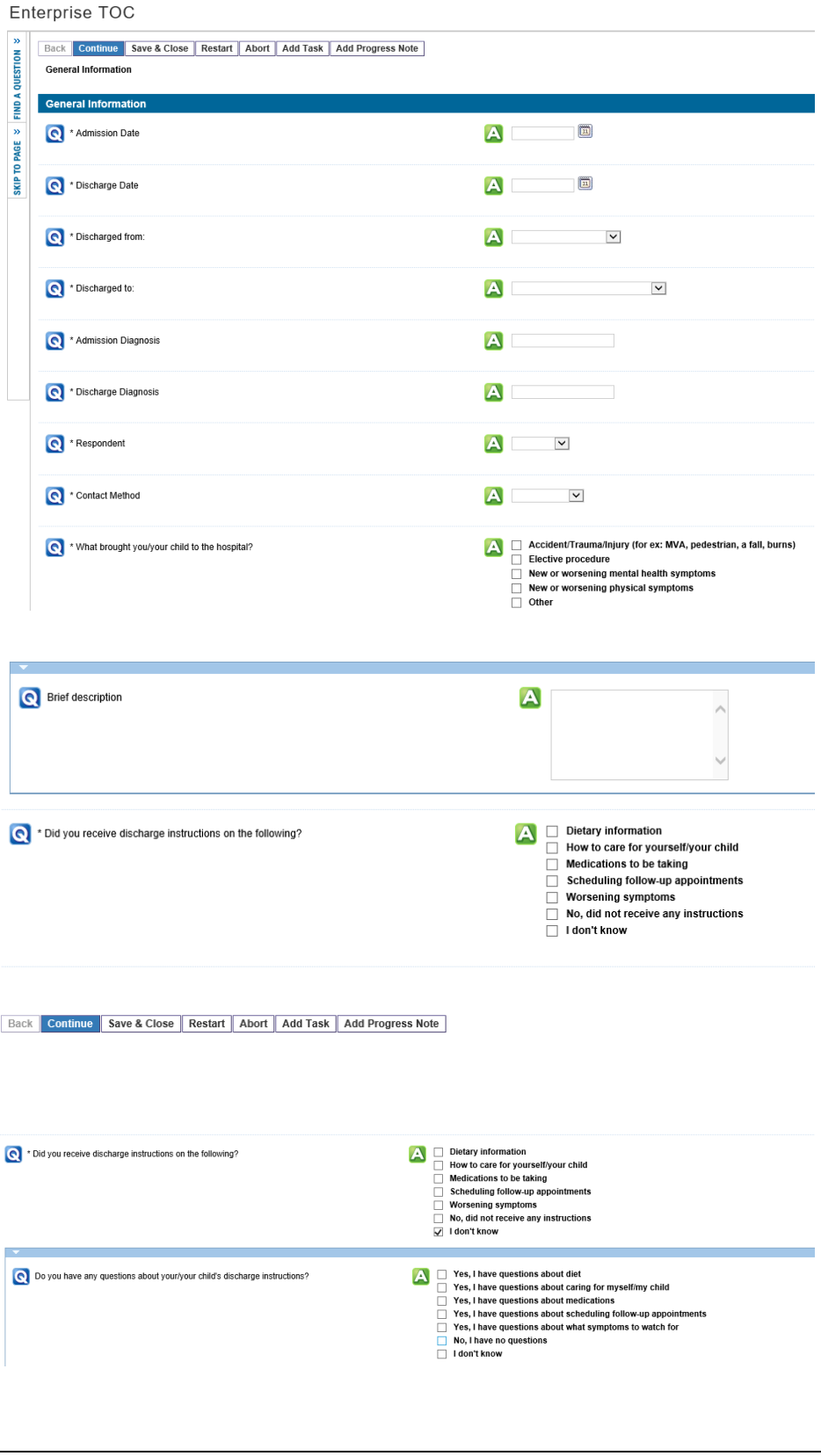
Transitions of Care

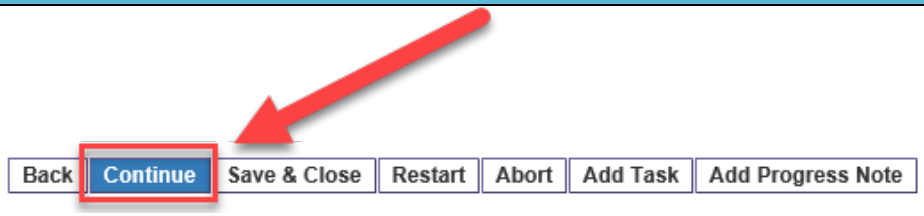
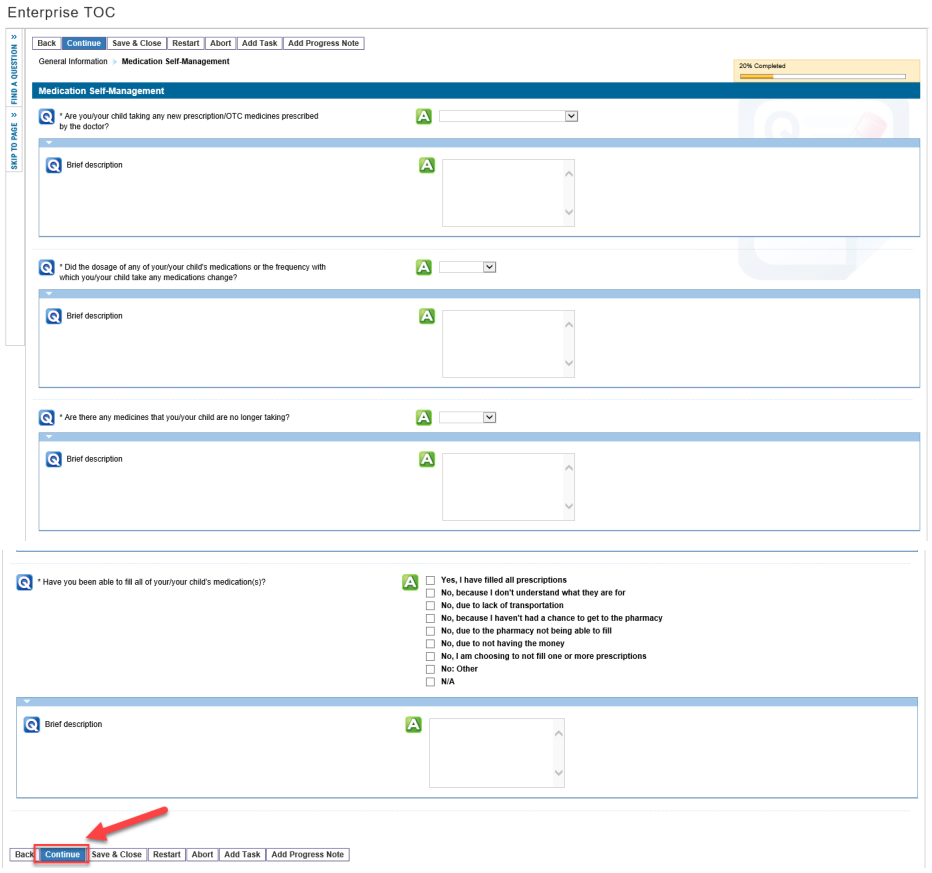
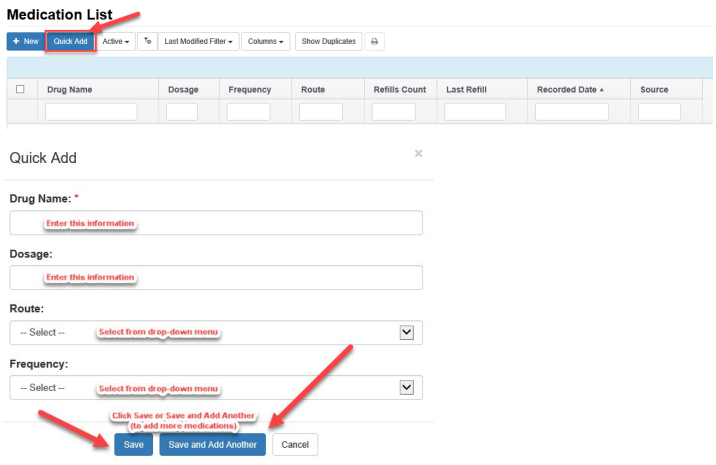
Molina will share hospital census data with ECM Providers electronically via sFTP. ECM Providers may also be able to learn about hospital admissions before Molina; therefore, ECM Providers must use all tools at their disposal to identify and interact with recently admitted/discharged members. ECM Providers must not rely solely on the census from Molina. ECM Providers must use hospital census data to identify ECM members who have been hospitalized and then complete the following activities:

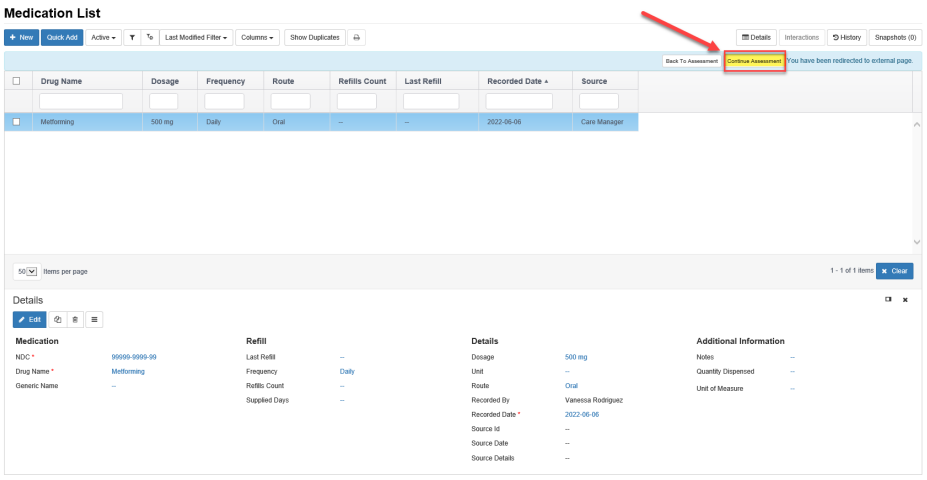
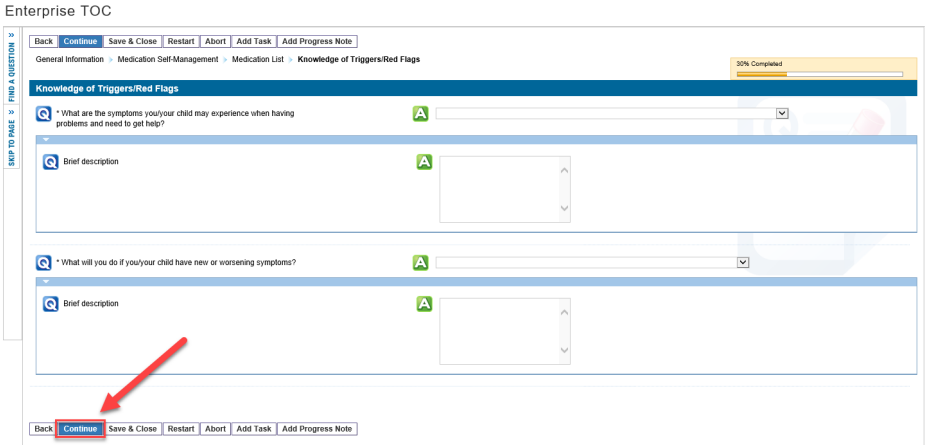
- Follow up with the member via telephone within **two business days** of discharge (or agreed upon date if contact is made with the member before discharge) to ensure any follow-up care needs are met, including assisting with scheduling needed follow-up appointments with PCP/Specialist. Outreach should include interventions to ensure follow-up needs are met.
- A face-to-face visit should occur within **seven business days** from discharge to determine the member's post-inpatient status and any further care needs and complete the Transition of Care assessment.
- ECM LCMs are expected to collaborate, communicate, and coordinate with all involved parties.
- A new HRA should be administered to the member, and the care plan should be updated post-discharge to address hospitalization and measures to prevent readmission.
- Updated ECM ICP should be shared with the member, PCP, and any parties involved in the patient's care.
- Evidence of coordination of all services for members during and post-care transitions from lower acuity facilities/departments (emergency departments, skilled nursing facilities, residential/treatment centers, incarceration facilities, etc. For Homeless members, the ECM Providers should plan an appropriate place for the member to stay post-discharge from the hospital or SNF, including temporary or permanent housing, and explore Community Supports referrals.

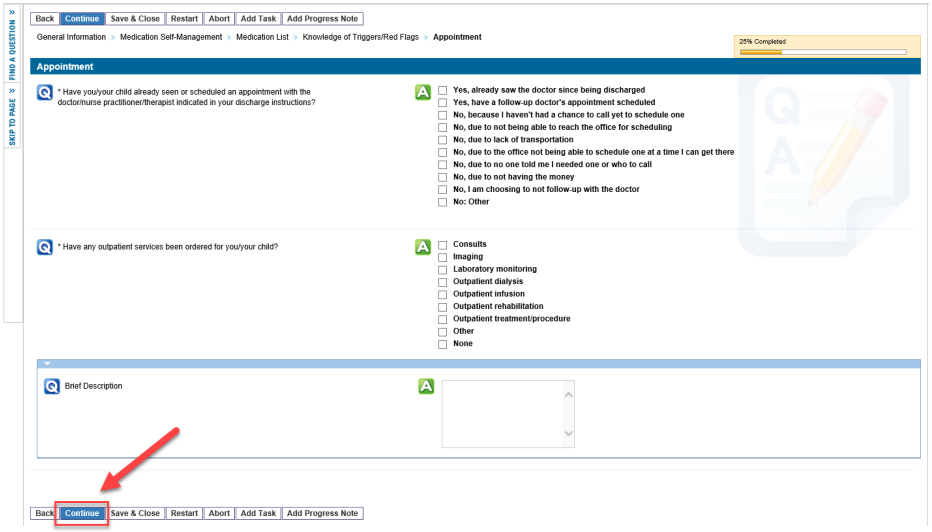
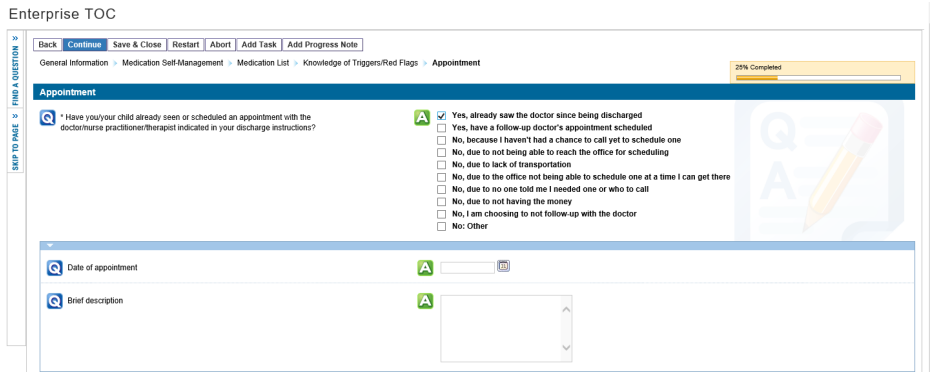
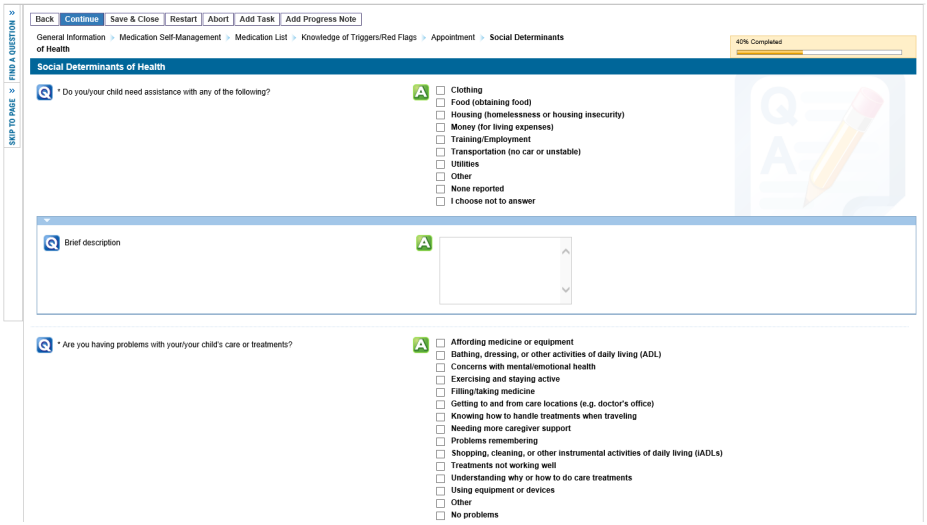
Follow the steps below to complete the Enterprise TOC assessment in CCA:

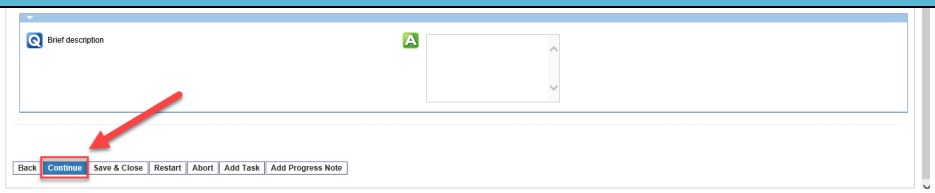
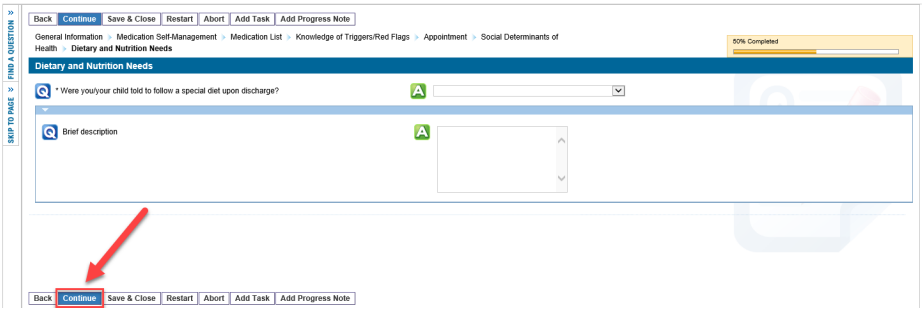
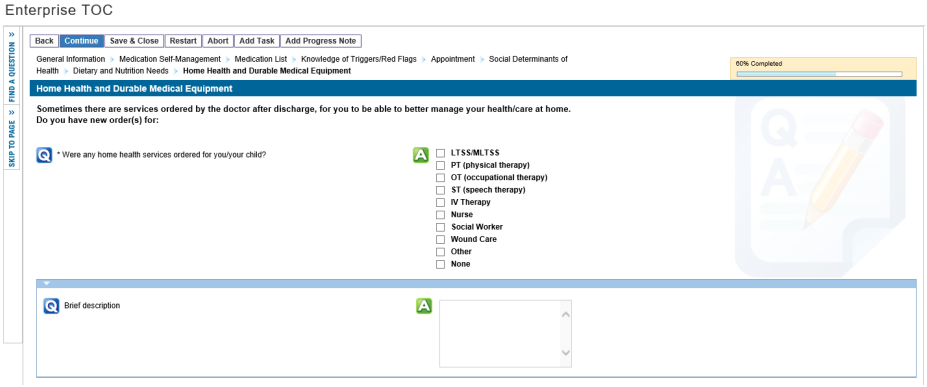
INSTRUCTIONS	SCREENSHOT
Step 1: Complete the Enterprise TOC Assessment. **How do I access the Enterprise TOC Assessment?** 1. Open CCA. 2. Search for your member and make sure the member is in focus. 3. Click on Assessments 4. Search for "Enterprise TOC" under *Name* and locate the "Enterprise TOC." 5. Click "Take Assessment."	

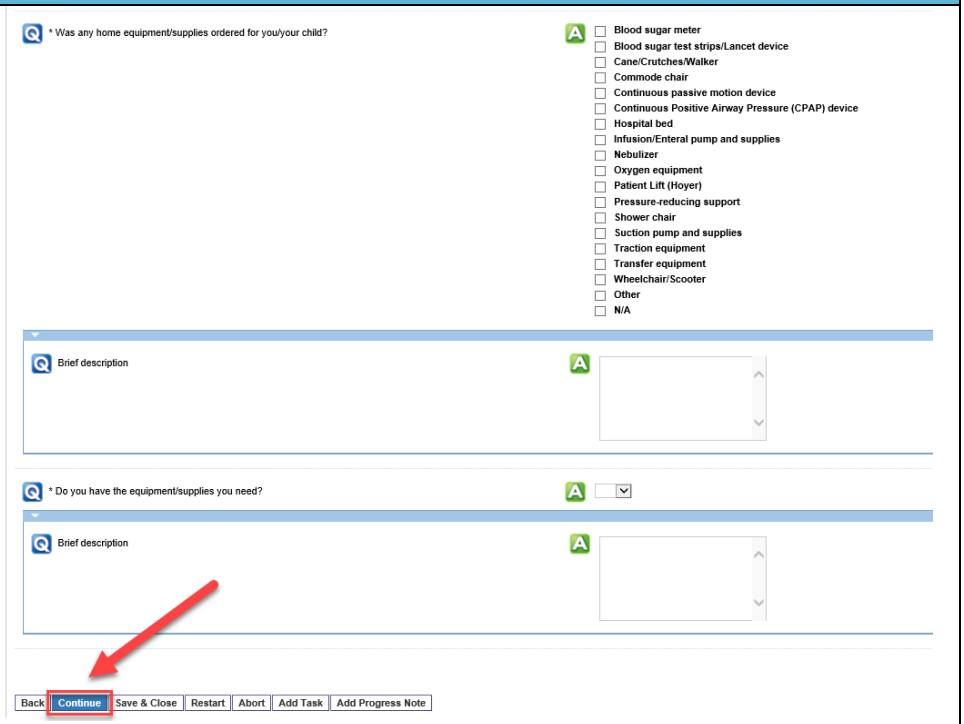
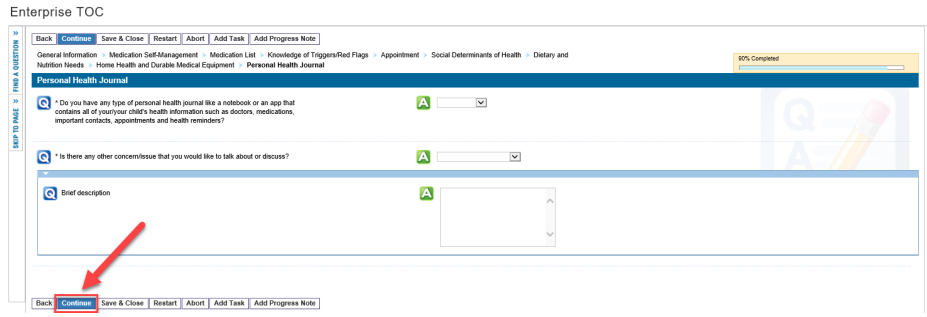
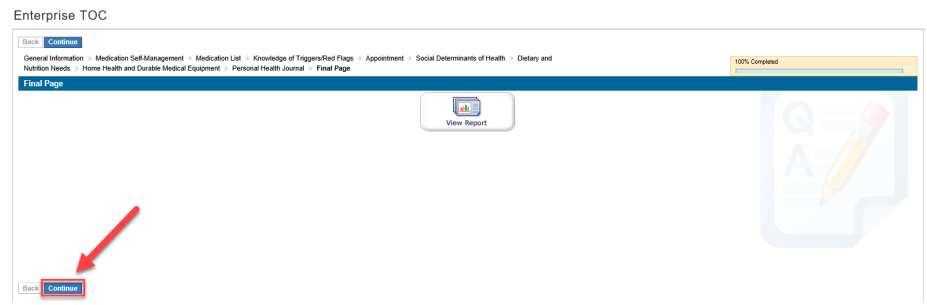
INSTRUCTIONS	SCREENSHOT
• The asterisk indicates mandatory questions. Complete questions in the "General Information" section. • The ToC Assessment has built-in branching logic. • You will frequently see the option "Other," which will populate a text box. It is recommended you answer using other options besides the "other" option and expand on your conversation within the documentation.	

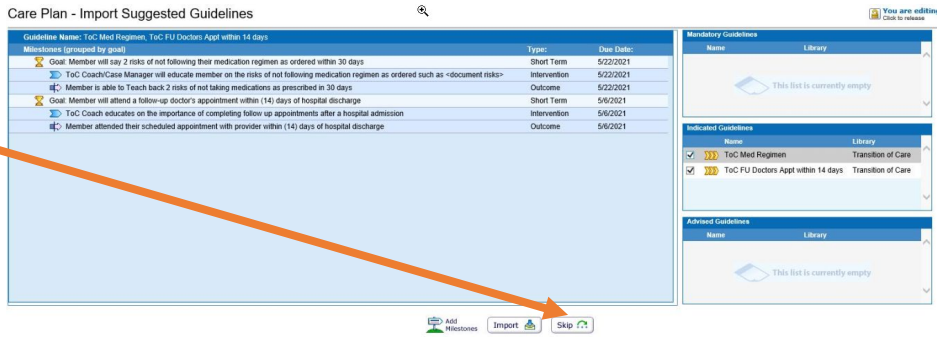
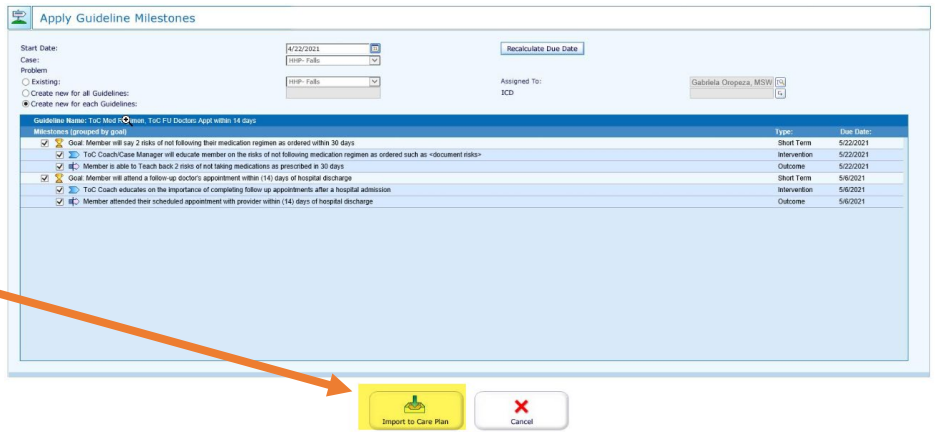
INSTRUCTIONS	SCREENSHOT
	
Next, complete the Medication Self-Management section of the TOC Assessment:	
Medication List Add the member's medication by clicking Quick Add. Enter the medication's information. Click Save or Save and Add Another (to add more medications). A list of Medications will populate. Select Continue	

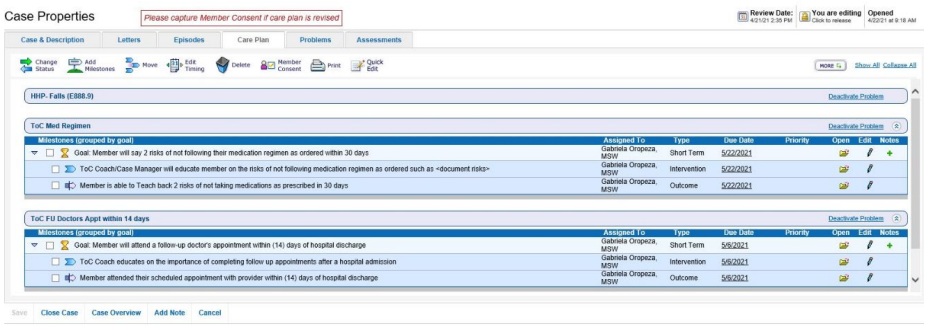
INSTRUCTIONS	SCREENSHOT
Assessment once all medications have been entered.	
Next, complete the Knowledge of Triggers/Red Flags section of the TOC Assessment: Here we are assessing member's understanding of the BH/ Physical Health related signs and symptoms of their condition and what to do when symptoms get worse/what to do in a crisis Documentation will support members' understanding of their triggers/emergency plans and evidence of self-management education. Responses to specific questions will prompt an ECM Care Plan goal to be auto-generated for placement in the Care Plan.	

INSTRUCTIONS	SCREENSHOT
Next, complete the Appointment section of the TOC Assessment: Documentation will support the appointment date. Suppose the member does not have a scheduled appointment. In that case, documentation will support education on the importance of the follow-up appointment and encouragement/assistance in securing and following through with the appointment. If the member states they need other appointments, documentation will support the need and why the member is stating they need this appointment. This documentation will be supported with the ECM Lead Care Manager interventions to act on that need	Enterprise TOC  If Yes, already saw the doctor since being discharged, fill-out branching questions: Enterprise TOC 
Next, complete the Social Determinants of Health section of the TOC Assessment: If the member does not have access to food, documentation should support the ECM Lead Care Manager's interventions to assist the member in identifying a food resource. If the member identifies support needs here, documentation should support the discussion of support systems and resources available.	Enterprise TOC 

INSTRUCTIONS	SCREENSHOT
	
Next, complete the Dietary and Nutrition Needs section of the TOC Assessment: If member identifies they have special diet instructions, documentation should support member's understanding of these restrictions and ECM Lead Care Manager education to support the specific diet	Enterprise TOC 
Next, complete the Home Health and Durable Medical Equipment section of the TOC Assessment: Documentation will support the member's identified need and why this is a need. Documentation should also support the ECM Lead Care Manager in addressing this need through education and/or assistance in obtaining the DME.	Enterprise TOC 

INSTRUCTIONS	SCREENSHOT
	
Next, complete the Personal Health Journal section of the TOC Assessment:	
You have now completed the TOC Assessment. Click Continue. The ECM Care Plan must be updated with any new coordination of care needs. Please see the ECM Care Plan section below for further guidance on this.	

INSTRUCTIONS	SCREENSHOT
ECM Care Plan The ECM Care Plan must be updated with any new coordination of care needs. Select the ECM Care Plan in CCA and edit (under Case Options).	
Assessment responses will potentially generate recommended guidelines to apply to the member's ECM Care Plan goals. Select any applicable guidelines for incorporation into the member's Care Plan.	
Import applicable goals into the ECM Care Plan.	
The next screen is where the import occurs. Click Import to Care Plan to update the ECM Care Plan with the new guidelines/goals.	

INSTRUCTIONS	SCREENSHOT
Once imported, the ECM Care Plan will update the new guidelines/goals. You can make any necessary edits/modifications to the ECM Care Plan here.	

Transitions of Care - Contact Forms

All activities involving Transitions of Care are required to be documented via a Contact Form in CCA; this includes evidence of coordination of all services for members during and post-care transitions from lower acuity facilities/departments (emergency departments, skilled nursing facilities, residential/treatment centers, incarceration facilities, etc.

Below is an example of how to complete a Contact Form in CCA:

<u>Scenario #1:</u> Post-enrollment. The member was discharged from the hospital. ECM Provider completed the Transitions of Care Assessment with the member within seven business days of discharge, new HRA, and updated care plan since there was a change in condition. Checked in with member and informed member he's working on coordinating doctor appointments.

Contact Form Fields	How to Complete Contact Form Fields
Subject	ECM Program - Best ECM Provider TOC Assessment Completion 6/1/23
Member First Name	John
Member Last Name	Smith
Contact Type	General Contact
Contact Date	06/01/2023
Contact Method	Face to Face - Home
Contact Method Other	
Contact Direction	Outbound
Respondent	Member
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM Post Discharge Outreach Assessment Care Plan Development/ Revision Coordination of Services
Purpose Of Contact Other	
Outcome Of Contact	Successful Contact
Outcome Of Contact Other	
Length Of Contact	60

Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 6/1/23, I conducted an in-person visit to the member's home. Member has been feeling better since leaving the hospital; however, experiencing very little pain. I completed the Transitions of Care Assessment, a new HRA, and updated the care plan since there was a change in condition. Member consented to care plan. I will also coordinate follow-up doctor appointments on behalf of the member.

Referrals

ECM Providers are required to make referrals to appropriate services/programs depending on their assigned member needs. These referrals need to be clearly documented via the Contact Form in CCA to evidence that follow-up on referrals was made, member needs were met, and care gaps were closed. All forms are located on Molina's website: https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx

Referrals to Community Support Services

ECM Providers are expected to refer members to Community Support services as applicable. For example, suppose a member is in the "Members Experiencing Homelessness" Population of Focus. In that case, the ECM LCM needs to complete a *Community Supports Housing Services Referral* (*Reminder: contact forms need to reflect that the member was referred to CS Housing Services*). Below is a complete list of the Community Support services that Molina offers. Molina's CS Team will host a separate training to discuss these Community Support services and review their process.

Community Supports	Imperial	Los Angeles (HN)	Riverside	Sacramento	San Bernardino	San Diego
Housing Transition Navigation Services	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Housing Deposits	7/1/2022	7/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Housing Tenancy and Sustaining Services	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Short-Term Post-Hospitalization	1/1/2024	1/1/2023	7/1/2022	7/1/2022	7/1/2022	1/1/2023
Recuperative Care (Medical Respite)	1/1/2024	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Respite Services	7/1/2022	1/1/2023	7/1/2022	7/1/2022	7/1/2022	7/1/2022
Day Habilitation Programs	7/1/2022	1/1/2023	7/1/2022	7/1/2022	7/1/2022	7/1/2022
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly and Adult Residential Facilities	1/1/2024	1/1/2023	1/1/2023	1/1/2024	1/1/2023	1/1/2024
Community Transition Services/Nursing Facility Transition to a Home	1/1/2023	1/1/2023	1/1/2022	1/1/2023	1/1/2022	1/1/2022
Personal Care and Homemaker Services	7/1/2022	1/1/2023	1/1/2022	1/1/2022	1/1/2022	1/1/2022

Community Supports	Imperial	Los Angeles (HN)	Riverside	Sacramento	San Bernardino	San Diego
Environmental Accessibility Adaptations (Home Modifications)	7/1/2023	7/1/2022	1/1/2023	7/1/2023	1/1/2023	7/1/2023
Medically Tailored Meals/Medically-Supportive Food	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022
Sobering Centers	1/1/2024	1/1/2022	1/1/2022	1/1/2022	1/1/2023	1/1/2022
Asthma Remediation	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022	1/1/2022

The CS Referral Forms are located on Molina's website:
https://www.molinahealthcare.com/providers/ca/medicaid/forms/fuf.aspx

Community-Based Adult Services (CBAS) and In-Home Supportive Services (IHSS)

Review the grids below for more information on Community Based Adult Services (CBAS) and In-Home Supportive Services (IHSS) and how to refer members:

Community-Based Adult Services (CBAS) and In-Home Supportive Services (IHSS) – Imperial County

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
Description of Program	A licensed community-based day health program that provides services to older adults and adults with chronic medical, cognitive, or mental health conditions and/or disabilities at risk of needing institutional care. **The goal is to keep vulnerable community members at home instead of in a skilled nursing facility. It also provides a respite solution for caregivers.**	Helps pay for in-home services such as personal care and homemaking. The goal is to help members remain safely in their homes, which is considered an alternative to out-of-home care. The IHSS recipient is the employer of his/her caregiver and is responsible for hiring and supervising.
Age Restrictions	18 years and older	65 years or older **OR** disabled **OR** blind
Included Services	Services at a CBAS center can include: • Professional nursing services • Social services or personal care services • Therapeutic activities • One meal per day Additional Services specified in the Member's Individual Care Plan (ICP): • Physical therapy • Occupational therapy • Speech therapy • Mental health services • Registered dietician services • Transportation to and from the CBAS center to your home	IHSS services can include: • Housecleaning • Meal preparation • Laundry • Grocery shopping • Personal care services (such as bowel and bladder care, bathing, and grooming) • Protective Supervision • Escorts to and from medical appointments (wait time is not authorized) • Paramedical Services under the direction of a licensed medical professional (such as wound care, catheter care, and tube feedings)
Who is Eligible?	To be eligible, the member must meet one of the following diagnostic categories: • Meets Nursing Facility Level of Care • Chronic acquired or traumatic brain injury and/or chronic mental illness • Alzheimer's disease or other dementia (stage 5, 6, or 7) • Mild cognitive impairment, including moderate Alzheimer's (stage 4 dementia) • Developmental disability (meet Regional Center criteria) • Has one or more chronic or post-acute medical, cognitive, or mental health conditions and a physician, nurse practitioner, or other health care provider, within his/her scope of practice, has requested CBAS services • Needs supervision or assistance with two or more of the following activities of daily living: bathing, dressing, feeding, toileting, ambulation, transferring, OR one ADL/IADL	To be eligible, the member must: • Be 65 years of age OR disabled OR blind • Also, be a California resident • Have a Medi-Cal eligibility determination • Live at home (acute care hospital, long-term care facilities, and licensed community care facilities are not considered "own home") • Be unable to live at home safely without help • Submit a completed Health Care Certification Form where a licensed health care professional certifies that the member is unable to perform ADL tasks independently and, without IHSS, would be at risk of placement in out-of-home care.

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
	listed above, along with money management, accessing resources, meal preparation or transportation • Currently an MSSP client, regional center client, eligible for specialty Mental Health Services, or receiving 195 or more IHSS hours	
Process	An outside organization (Partners in Care) conducts an eligibility assessment using the CBAS Eligibility Determination Tool (CEDT). If the member qualifies, they choose the center they wish to attend and schedule an assessment at the center. The interdisciplinary team collaborates and develops an Individualized Plan of Care (IPC).	A county social worker conducts an in-home assessment to determine eligibility and need for IHSS. Based on the need for assistance with ADLs/ IADLs, the social worker will assess the types of services needed and the number of hours the county will authorize for each of these services. If the member does not have a friend or family member available to hire as a caregiver, they can contact the Public Authority office for assistance. The Public Authority maintains a Registry of pre-screened caregivers.
Referral Process	**Standard referral:** The CBAS referral form (along with H&P) is submitted to UM by the CBAS center. Submit an email to CALTSS@molinahealthcare.com mailbox for assistance with the process.	**Standard referral:** Contact Imperial County In-Home Supportive Services directly: Phone: (760) 337-3084 **Redeterminations:** Members may be eligible for a redetermination of hours if the member has experienced a significate change in functional ability. Assist member in contacting Imperial IHSS: (760) 337-3084 **Public Authority:**- Assist member in contacting Imperial County IHSS Public Authority: (760) 337-6851
Document Referral – Contact Form	Contact Form in CCA: When a referral for CBAS is made, please complete a Contact Form. Complete the "Adult Day Healthcare" category referring to CBAS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral Made	Contact Form in CCA: When a referral for IHSS is made, please complete a Contact Form. Complete the "Personal Care Assistance" category referring to IHSS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
	Only fill out when the member is initially assessed and/or when referred to a resource.	- Referral made Only fill out when the member is initially assessed and/or when referred to a resource.

Community-Based Adult Services (CBAS) and In-Home Supportive Services (IHSS) – Inland Empire (Riverside and San Bernardino Counties)

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
Description of Program	A licensed community-based day health program that provides services to older adults and adults with chronic medical, cognitive, or mental health conditions and/or disabilities at risk of needing institutional care. **The goal is to keep vulnerable community members at home instead of in a skilled nursing facility. It also provides a respite solution for caregivers.**	Helps pay for in-home services such as personal care and homemaking. The goal is to help members remain safely in their homes, which is considered an alternative to out-of-home care. The IHSS recipient is the employer of his/her caregiver and is responsible for hiring and supervising.
Age Restrictions	18 years and older	65 years or older **OR** disabled **OR** blind
Included Services	Services at a CBAS center can include: • Professional nursing services • Social services or personal care services • Therapeutic activities • One meal per day Additional Services specified in the member's Individual Care Plan (ICP): • Physical therapy • Occupational therapy • Speech therapy • Mental health services • Registered dietician services • Transportation to and from the CBAS center to your home	IHSS services can include: • Housecleaning • Meal preparation • Laundry • Grocery shopping • Personal care services (such as bowel and bladder care, bathing, and grooming) • Protective Supervision • Escorts to and from medical appointments (wait time is not authorized) • Paramedical Services under the direction of a licensed medical professional (such as wound care, catheter care, and tube feedings)
Who is Eligible?	To be eligible, the member must meet one of the following diagnostic categories: • Meets Nursing Facility Level of Care • Chronic acquired or traumatic brain injury and/or chronic mental illness • Alzheimer's disease or other dementia (stage 5, 6, or 7) • Mild cognitive impairment, including moderate Alzheimer's (stage 4 dementia)	To be eligible, the member must: • Be 65 years of age OR disabled OR blind • Also, be a California resident • Have a Medi-Cal eligibility determination • Live at home (acute care hospital, long-term care facilities, and licensed community care facilities are not considered "own home") • Be unable to live at home safely without help

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
	• Developmental disability (meet Regional Center criteria) • Has one or more chronic or post-acute medical, cognitive, or mental health conditions and a physician, nurse practitioner, or other health care provider, within his/her scope of practice, has requested CBAS services • Needs supervision or assistance with two or more of the following activities of daily living: bathing, dressing, feeding, toileting, ambulation, transferring, OR one ADL/IADL listed above, along with money management, accessing resources, meal preparation or transportation Currently an MSSP client, regional center client, eligible for specialty Mental Health Services, or receiving 195 or more IHSS hours	Submit a completed Health Care Certification Form where a licensed health care professional certifies that the member is unable to perform ADL tasks independently and, without IHSS, would be at risk of placement in out-of-home care.
Process	An outside organization (Partners in Care) conducts an eligibility assessment using the CBAS Eligibility Determination Tool (CEDT). If the member qualifies, they choose the center they wish to attend and schedule an assessment at the center. The interdisciplinary team collaborates and develops an Individualized Plan of Care (IPC).	A county social worker conducts an in-home assessment to determine eligibility and need for IHSS. Based on the need for assistance with ADLs /IADLs, the social worker will assess the types of services needed and the number of hours the county will authorize for each of these services. If the member does not have a friend or family member available to hire as a caregiver, they can contact the Public Authority office for assistance. The Public Authority maintains a Registry of pre-screened caregivers.
Referral Process Referral Process (cont.)	**Standard referral:** The CBAS referral form (along with H&P) is submitted to UM by the CBAS center. Submit an email to CALTSS@molinahealthcare.com mailbox for assistance with the process.	**Standard referral:** San Bernardino: Submit the county IHSS Referral form to Molina through the Molina CA LTSS mailbox at CALTSS@molinahealthcare.com. Riverside: Contact the Department of Public Social Services (DPSS) to initiate an IHSS referral: Web Referral: https://riversideihss.org/Home/IHSSApply • After a referral is made, download the referral and email it to the LTSS mailbox at CALTSS@molinahealthcare.com, for tracking purposes. **Redeterminations:** Members may be eligible for a redetermination of hours if the member has experienced a significate change in functional ability.

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
		Submit an email to Molina through the Molina CA LTSS mailbox at CALTSS@molinahealthcare.com. Flag referral as redetermination and provide justification. **Public Authority:** Submit an email to Molina through the Molina CA LTSS mailbox at CALTSS@molinahealthcare.com.
Document Referral – Contact Form	Contact Form in CCA: When a referral for CBAS is made, please complete a Contact Form. Complete the "Adult Day Healthcare" category referring to CBAS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral Made Only fill out when the member is initially assessed and/or when referred to a resource.	Contact Form in CCA: When a referral for IHSS is made, please complete a Contact Form. Complete the "Personal Care Assistance" category referring to IHSS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral made Only fill out when the member is initially assessed and/or when referred to a resource.
Contact Information	Link to State-Approved CBAS Providers (sort by county): https://www.aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/CBAS_Providers/	Riverside County • IHSS: (888) 960-4477 • Public Authority: (888) 960-4477 San Bernardino County • IHSS: (877) 800-4544 • Public Authority: (866) 985-6322

Community-Based Adult Services (CBAS) and In-Home Supportive Services (IHSS) – Los Angeles County

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
Description of Program	A licensed community-based day health program that provides services to older adults and adults with chronic medical, cognitive, or mental health	Helps pay for in-home services such as personal care and homemaking. The goal is to help members remain safely in their homes, which is considered an alternative to out-of-home care.

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
	conditions and/or disabilities at risk of needing institutional care. The goal is to keep vulnerable community members at home instead of in a skilled nursing facility. It also provides a respite solution for caregivers.	The IHSS recipient is the employer of his/her caregiver and is responsible for hiring and supervising.
Age Restrictions	18 years and older	65 years or older **OR** disabled **OR** blind
Included Services	Services at a CBAS center can include: • Professional nursing services • Social services or personal care services • Therapeutic activities • One meal per day Additional Services specified in the Member's Individual Care Plan (ICP): • Physical therapy • Occupational therapy • Speech therapy • Mental health services • Registered dietician services • Transportation to and from the CBAS center to your home	IHSS services can include: • Housecleaning • Meal preparation • Laundry • Grocery shopping • Personal care services (such as bowel and bladder care, bathing, and grooming) • Protective Supervision • Escorts to and from medical appointments (wait time is not authorized) • Paramedical Services under the direction of a licensed medical professional (such as wound care, catheter care, and tube feedings)
Who is Eligible?	To be eligible, the member must meet one of the following diagnostic categories: • Meets Nursing Facility Level of Care • Chronic acquired or traumatic brain injury and/or chronic mental illness • Alzheimer's disease or other dementia (stage 5, 6, or 7) • Mild cognitive impairment, including moderate Alzheimer's (stage 4 dementia) • Developmental disability (meet Regional Center criteria) • Has one or more chronic or post-acute medical, cognitive, or mental health conditions and a physician, nurse practitioner, or other health care provider, within his/her scope of practice, has requested CBAS services • Needs supervision or assistance with two or more of the following activities of daily living: bathing, dressing, feeding, toileting, ambulation, transferring, OR one ADL/IADL listed above, along with money management, accessing resources, meal preparation or transportation	To be eligible, the member must: • Be 65 years of age OR disabled OR blind • Also, be a California resident • Have a Medi-Cal eligibility determination • Live at home (acute care hospital, long-term care facilities, and licensed community care facilities are not considered "own home") • Be unable to live at home safely without help. • Submit a completed Health Care Certification Form where a licensed health care professional certifies that the member is unable to perform ADL tasks independently and, without IHSS, would be at risk of placement in out-of-home care.

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
	• Currently an MSSP client, regional center client, eligible for specialty Mental Health Services, or receiving 195 or more IHSS hours	
Process	An outside organization (Partners in Care) conducts an eligibility assessment using the CBAS Eligibility Determination Tool (CEDT). If the member qualifies, they choose the center they wish to attend and schedule an assessment at the center. The interdisciplinary team collaborates and develops an Individualized Plan of Care (IPC).	A county social worker conducts an in-home assessment to determine eligibility and need for IHSS. Based on the need for assistance with ADLs/ IADLs, the social worker will assess the types of services needed and the number of hours the county will authorize for each of these services. If the member does not have a friend or family member available to hire as a caregiver, they can contact the Public Authority office for assistance. The Public Authority maintains a Registry of pre-screened caregivers.
Referral Process Referral Process cont.	**Standard referral:** The CBAS referral form (along with H&P) is submitted to UM by the CBAS center. Submit an email to CALTSS@molinahealthcare.com mailbox for assistance with the process.	**Standard referral:** Submit Los Angeles County IHSS Referral Form to Molina through the Molina CA LTSS mailbox at: CALTSS@molinahealthcare.com. **Redeterminations:** Members may be eligible for a redetermination of hours if the member has experienced a significate change in functional ability. Assist the member in contacting IHSS Helpline: (888) 822-9622 **Public Authority-** Assist member in contacting Personal Assistance Service Council (PASC): (877) 565-4477
Document Referral – Contact Form	Contact Form in CCA: When a referral for CBAS is made, please complete a Contact Form. Complete the “Adult Day Healthcare” category referring to CBAS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral Made	Contact Form in CCA: When a referral for IHSS is made, please complete a Contact Form. Complete the “Personal Care Assistance” category referring to IHSS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral made

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
	Only fill out when the member is initially assessed and/or when referred to a resource.	Only fill out when the member is initially assessed and/or when referred to a resource.
Contact Information	Link to State-Approved CBAS Providers (sort by county): https://www.aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/CBAS_Providers/	**Los Angeles County** • IHSS: (888) 944-4477 • IHSS Helpline: (888) 822-9622 • Public Authority: (877) 565-4477

Community-Based Adult Services (CBAS) and In-Home Supportive Services (IHSS) – Sacramento County

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
Description of Program	A licensed community-based day health program that provides services to older adults and adults with chronic medical, cognitive, or mental health conditions and/or disabilities at risk of needing institutional care. The goal is to keep vulnerable community members at home instead of in a skilled nursing facility. It also provides a respite solution for caregivers.	Helps pay for in-home services such as personal care and homemaking. The goal is to help members remain safely in their homes, which is considered an alternative to out-of-home care. The IHSS recipient is the employer of his/her caregiver and is responsible for hiring and supervising.
Age Restrictions	18 years and older	65 years or older **OR** disabled **OR** blind
Included Services	Services at a CBAS center can include: • Professional nursing services • Social services or personal care services • Therapeutic activities • One meal per day Additional Services specified in the Member's Individual Care Plan (ICP): • Physical therapy • Occupational therapy • Speech therapy • Mental health services • Registered dietician services	IHSS services can include: • Housecleaning • Meal preparation • Laundry • Grocery shopping • Personal care services (such as bowel and bladder care, bathing, and grooming) • Protective Supervision • Escorts to and from medical appointments (wait time is not authorized) • Paramedical Services under the direction of a licensed medical professional (such as wound care, catheter care, and tube feedings)

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
	• Transportation to and from the CBAS center to your home	
Who is Eligible?	To be eligible, the member must meet one of the following diagnostic categories: • Meets Nursing Facility Level of Care • Chronic acquired or traumatic brain injury and/or chronic mental illness • Alzheimer's disease or other dementia (stage 5, 6, or 7) • Mild cognitive impairment, including moderate Alzheimer's (stage 4 dementia) • Developmental disability (meet Regional Center criteria) • Has one or more chronic or post-acute medical, cognitive, or mental health conditions and a physician, nurse practitioner, or other health care provider, within his/her scope of practice, has requested CBAS services • Needs supervision or assistance with two or more of the following activities of daily living: bathing, dressing, feeding, toileting, ambulation, transferring, OR one ADL/IADL listed above, along with money management, accessing resources, meal preparation or transportation Currently an MSSP client, regional center client, eligible for specialty Mental Health Services, or receiving 195 or more IHSS hours	To be eligible, the member must: • Be 65 years of age OR disabled OR blind • Also, be a California resident • Have a Medi-Cal eligibility determination • Live at home (acute care hospital, long-term care facilities, and licensed community care facilities are not considered "own home") • Be unable to live at home safely without help • Submit a completed Health Care Certification Form where a licensed health care professional certifies that the member is unable to perform ADL tasks independently and, without IHSS, would be at risk of placement in out-of-home care.
Process	An outside organization (Partners in Care) conducts an eligibility assessment using the CBAS Eligibility Determination Tool (CEDT). If the member qualifies, they choose the center they wish to attend and schedule an assessment at the center. The interdisciplinary team collaborates and develops an Individualized Plan of Care (IPC).	A county social worker conducts an in-home assessment to determine eligibility and need for IHSS. Based on the need for assistance with ADLs/IADLs, the social worker will assess the types of services needed and the number of hours the county will authorize for each of these services. If the member does not have a friend or family member available to hire as a caregiver, they can contact the Public Authority office for assistance. The Public Authority maintains a Registry of pre-screened caregivers.

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
Referral Process	**Standard referral:** The CBAS referral form (along with H&P) is submitted to UM by the CBAS center. Submit an email to CALTSS@molinahealthcare.com mailbox for assistance with the process.	**Standard referral:** Contact Sacramento County In-Home Supportive Services directly: Phone: (916) 874-9471 **Redeterminations:** Members may be eligible for a redetermination of hours if the member has experienced a significate change in functional ability. Assist member to contact Sacramento County IHSS: (916) 874-9471 **Public Authority-** Assist member to contact Sacramento County IHSS Public Authority: (916) 874-2888
Document Referral – Contact Form	Contact Form in CCA: When a referral for CBAS is made, please complete a Contact Form. Complete the "Adult Day Healthcare" category referring to CBAS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral Made Only fill out when the member is initially assessed and/or when referred to a resource.	Contact Form in CCA: When a referral for IHSS is made, please complete a Contact Form. Complete the "Personal Care Assistance" category referring to IHSS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral made Only fill out when the member is initially assessed and/or when referred to a resource.
Contact Information	Link to State-Approved CBAS Providers (sort by county): https://www.aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/CBAS_Providers/	**Sacramento County** • IHSS: (916) 874-9471 • Public Authority: (916) 874-2888

Community-Based Adult Services (CBAS) and In-Home Supportive Services (IHSS) – San Diego County

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
Description of Program	A licensed community-based day health program that provides services to older adults and adults with chronic medical, cognitive, or mental health conditions and/or disabilities at risk of needing institutional care. The goal is to keep vulnerable community members at home instead of in a skilled nursing facility. Also provides a respite solution for caregivers.	Helps pay for in-home services such as personal care and homemaking. The goal is to help members remain safely in their homes, which is considered an alternative to out-of-home care. The IHSS recipient is the employer of his/her caregiver and is responsible for hiring and supervising.
Age Restrictions	18 years and older	65 years or older **OR** disabled **OR** blind
Included Services	Services at a CBAS center can include: • Professional nursing services • Social services or personal care services • Therapeutic activities • One meal per day Additional Services specified in the Member's Individual Care Plan (ICP): • Physical therapy • Occupational therapy • Speech therapy • Mental health services • Registered dietician services • Transportation to and from the CBAS center to your home	IHSS services can include: • Housecleaning • Meal preparation • Laundry • Grocery shopping • Personal care services (such as bowel and bladder care, bathing, and grooming) • Protective Supervision • Escorts to and from medical appointments (wait time is not authorized) • Paramedical Services under the direction of a licensed medical professional (such as wound care, catheter care, and tube feedings)
Who is Eligible?	To be eligible, the member must meet one of the following diagnostic categories: • Meets Nursing Facility Level of Care • Chronic acquired or traumatic brain injury and/or chronic mental illness • Alzheimer's disease or other dementia (stage 5, 6, or 7) • Mild cognitive impairment, including moderate Alzheimer's (stage 4 dementia) • Developmental disability (meet Regional Center criteria) • Has one or more chronic or post-acute medical, cognitive, or mental health conditions and a physician, nurse practitioner, or other health care provider, within his/her scope of practice, has requested CBAS services • Needs supervision or assistance with two or more of the following activities of daily living: bathing, dressing, feeding, toileting, ambulation, transferring, OR one ADL/IADL listed above,	To be eligible, the member must: • Be 65 years of age OR disabled OR blind • Also, be a California resident • Have a Medi-Cal eligibility determination • Live at home (acute care hospital, long-term care facilities, and licensed community care facilities are not considered "own home") • Be unable to live at home safely without help. • Submit a completed Health Care Certification Form where a licensed health care professional certifies that the member is unable to perform ADL tasks independently and, without IHSS, would be at risk of placement in out-of-home care.

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
	along with money management, accessing resources, meal preparation or transportation Currently an MSSP client, regional center client, eligible for specialty Mental Health Services, or receiving 195 or more IHSS hours	
Process	An outside organization (Partners in Care) conducts an eligibility assessment using the CBAS Eligibility Determination Tool (CEDT). If the member qualifies, they choose the center they wish to attend and schedule an assessment at the center. The interdisciplinary team collaborates and develops an Individualized Plan of Care (IPC).	A county social worker conducts an in-home assessment to determine eligibility and need for IHSS. Based on the need for assistance with ADLs / IADLs, the social worker will assess the types of services needed and the number of hours the county will authorize for each of these services. If the member does not have a friend or family member available to hire as a caregiver, they can contact the Public Authority office for assistance. The Public Authority maintains a Registry of pre-screened caregivers.
Referral Process	**Standard referral:** The CBAS referral form (along with H&P) is submitted to UM by the CBAS center. Submit an email to CALTSS@molinahealthcare.com mailbox for assistance with the process.	**Standard referral:** Contact Aging and Independence Services (AIS) to initiate an IHSS referral: Phone: (800) 339-4661 Web Referral: Register and complete referrals https://www.aiswebreferral.org/Account/Login.aspx?ReturnUrl=%2f **Redeterminations:** Members may be eligible for a redetermination of hours if the member has experienced a significate change in functional ability. Assist member in contacting AIS: (800) 339-4661 **Public Authority-** Assist member in contacting San Diego IHSS Public Authority: (866) 351-7722

	Community-Based Adult Services (CBAS)	In-Home Supportive Services (IHSS)
Document Referral – Contact Form	Contact Form in CCA: When a referral for CBAS is made, please complete a Contact Form. Complete the "Adult Day Healthcare" category referring to CBAS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral Made Only fill out when the member is initially assessed and/or when referred to a resource.	Contact Form in CCA: When a referral for IHSS is made, please complete a Contact Form. Complete the "Personal Care Assistance" category referring to IHSS and elect one (1) from the following options: - Existing Service - Offered but Declined by Member/Family - Referral made Only fill out when the member is initially assessed and/or when referred to a resource.
Contact Information	Link to State-Approved CBAS Providers (sort by county): https://www.aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/CBAS_Providers/	San Diego County • IHSS: (800) 339-4661 • Public Authority: (866) 351-7722

Disenrolling Members from ECM

If a member needs to be disenrolled from ECM, the ECM LCM must complete the Disenrollment Form in CCA. Please note that a Disenrollment Form does not need to be completed for members not enrolled in the program.

Below is the complete list of disenrollment reasons:

1. All care goals are met= Member's conditions are well-managed, and goals have been met. No additional problems have been identified; therefore, ECM services are no longer needed, and the member is ready to graduate from the program.
2. Member is ready to transition to a lower level of care= Member is ready to be downgraded to a lower level of care management. Complete a direct referral to Molina's CM prior to disenrolling member from ECM.
3. Member no longer wishes to receive ECM or is unwilling to engage= Member does not want to be in the program at this time or is unwilling to engage. This can include instances when a member's behavior or environment is unsafe for the ECM Provider.
4. ECM provider has been unable to connect with the member after multiple attempts= Member is unable to be contacted. Also, if you are made aware that a member will be out of the state/country for longer than 30 days, the member needs to be disenrolled from ECM immediately (do not delay disenrolling the member). However, if you are informed that the member is out of the state/country and don't know the member's return date, wait 30 days from the date of identification, and if the member continues to be out of the state/country past the 30 days, proceed with disenrolling the member.
5. Member is enrolled in a duplicative program= Some ECM-eligible members may be receiving services from another DHCS-approved program. In some cases, the member may choose to enroll in the ECM, and in some cases, they cannot enroll at all. For a complete list of Duplicative Programs, see the latest ECM Policy Guide. Please note that Molina does not consider MedZed HC 2.0, My Palliative Care, & Major Organ Transplant duplicative programs; ECM members can be enrolled in these programs if services are not duplicative.
6. Not enrolled with Molina Medi-Cal program= The member is no longer eligible for Medi-Cal benefits through Molina Healthcare.
7. Member passed away=. The member has expired.

Members' disenrollment can be voluntary or involuntary. If disenrolling the member involuntarily, attempts must be made to notify the member, documented via a contact form in CCA, and all required correspondence mailed prior to disenrolling the member. If the ECM LCM is unable to mail the Post Opt-In UTC Letter or Post Opt-In Decline Letter to a member due to no address on record or wrong address, the ECM LCM will indicate this in the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form. If a member no longer wishes to be in the ECM Program, the ECM LCM must use the date of discussion as the date of disenrollment in the Disenrollment Form. The ECM LCM must follow the outreach attempts and guidelines outlined in the *Contact Forms & Attempts* section above.

The ECM LCM must close the care plan, milestones, and pending tasks before completing the Disenrollment Form. In addition, the ECM LCM must remove themselves from the Assignments section in CCA and the Address Book before submitting the Disenrollment Form.

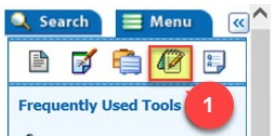
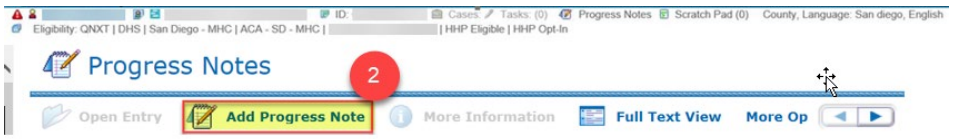
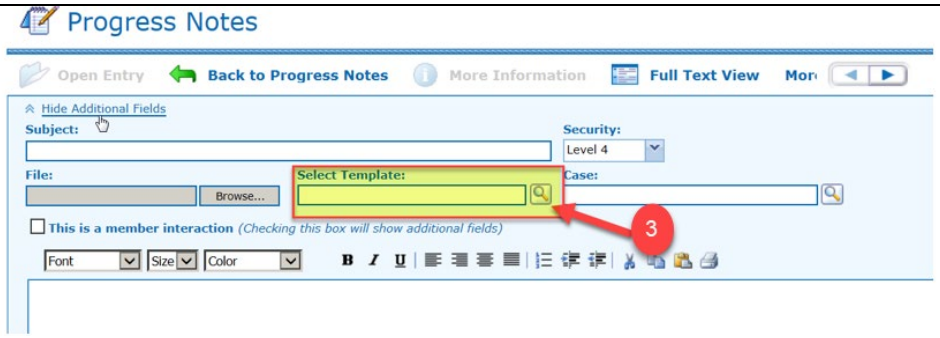
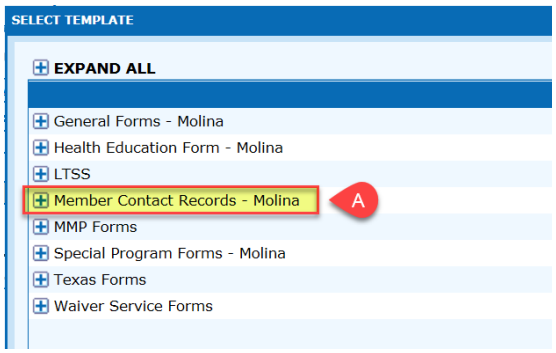
We defer to our ECM Providers to apply their own judgment to determine if a member should continue with ECM, must be downgraded to a lower level of care (Molina CM), or graduated completely from the ECM program. Our ECM providers can determine this through monitoring the member's care plan goals and the completion of the HRA reassessments they are required to complete with the member every six months (or sooner if there's a change in condition, i.e., hospitalization) if the same concerns exist, or if new ones have come up which still require the member to be managed through ECM. We want our ECM Providers also to consider the following when deciding this:

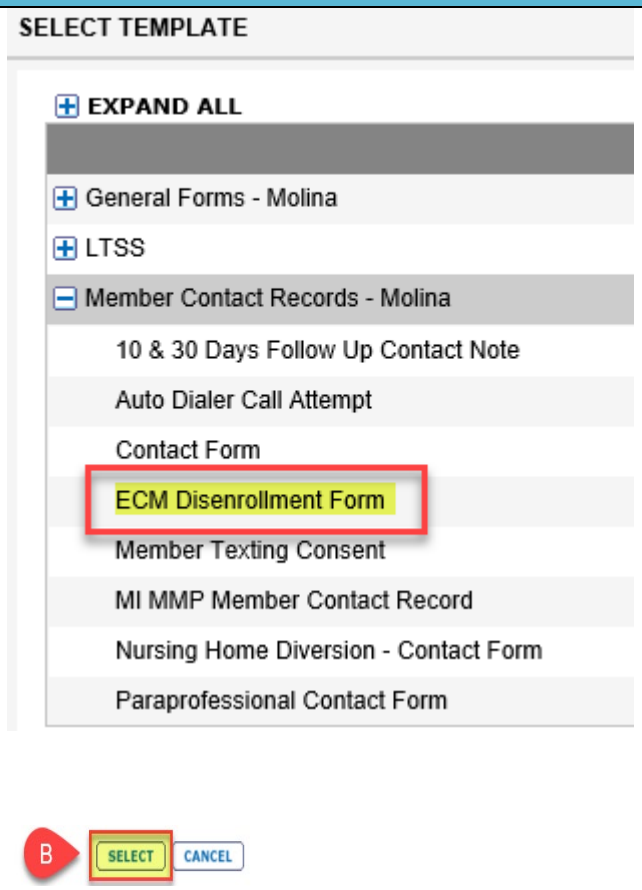
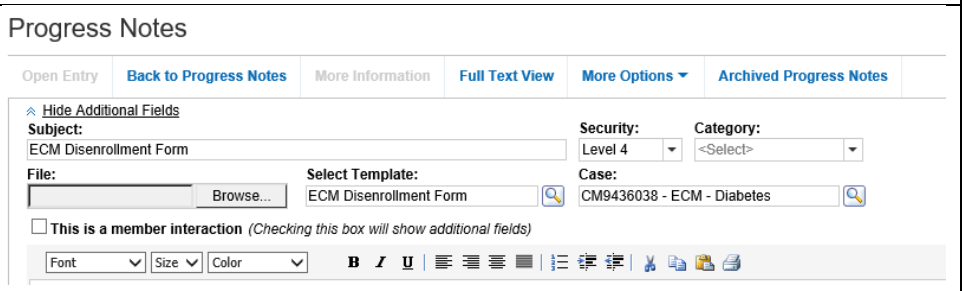
- Has the member's ED/ inpatient utilization gone down?

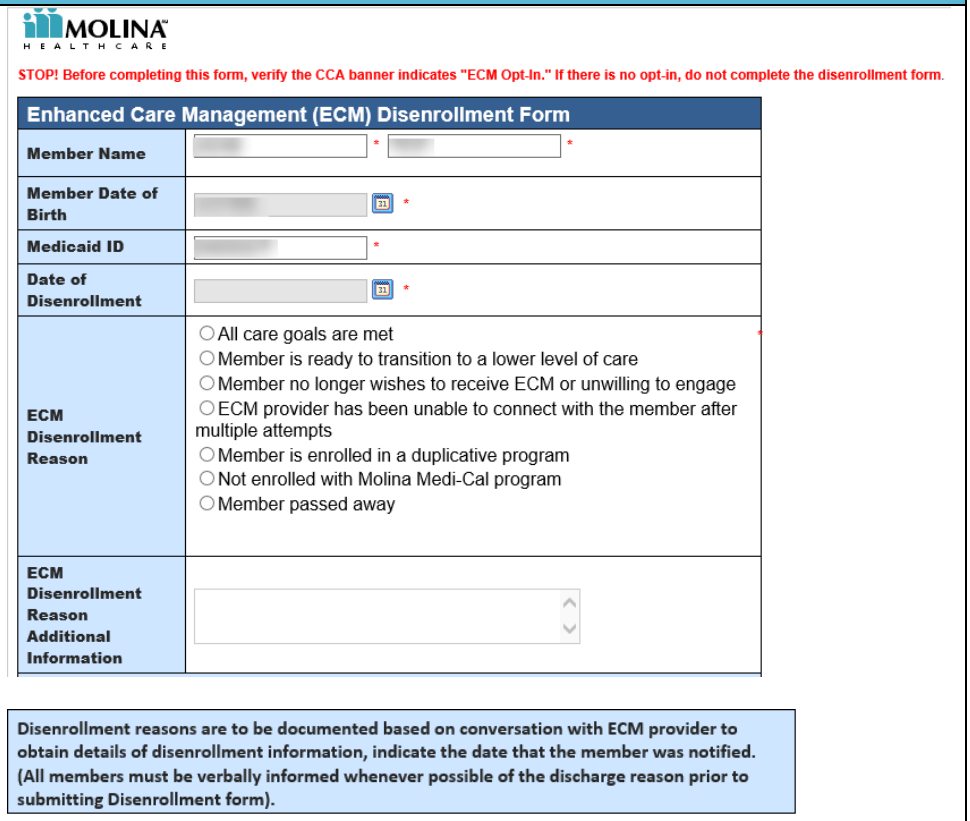
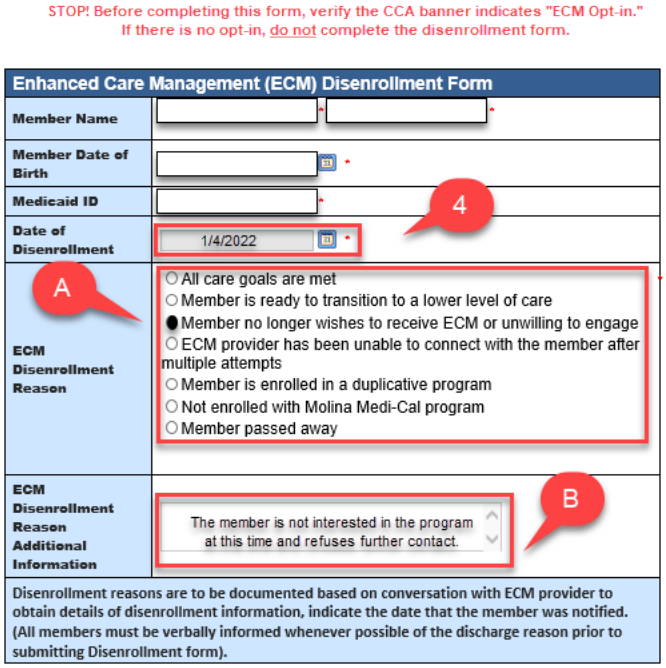
- Is the member self-managing, getting to appointments on their own? Taking their meds? Plugged in with PCP and specialists?

- Does the member have stable housing?

Follow the steps below to disenroll a member from our ECM Program:

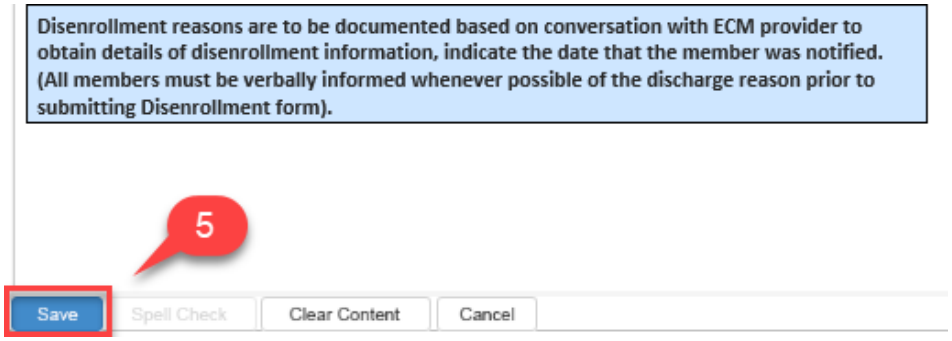
INSTRUCTIONS	SCREENSHOT
1. Select the Progress Notes Icon from the Vertical Menu Bar	
2. Select "Add Progress Note" to access the templates for ECM.	
3. Use the magnifying glass to see the categories of progress notes. Next, from the list (A), expand the "Member Contact Records – Molina" group,	 

INSTRUCTIONS	SCREENSHOT
Then (B) highlight the ECM Disenrollment form and click “Select.”	
4. The disenrollment form will now display. Subject, Security, and Select Template fields will auto-populate.	

INSTRUCTIONS	SCREENSHOT
	
(A) In the Enhanced Care Management (ECM) Disenrollment Form form, use the calendar picker to select the disenrollment date for the member. **Ensure that the member reflects as an "ECM Opt-in" member per the CCA banner. Do not complete the form if there is no indication of opt-in.** Choose the **ECM Disenrollment Reason**: **All care goals are met**= Member's conditions are well-managed, and goals have been met. No additional problems have been identified; therefore, ECM services are no longer needed, and member is	

INSTRUCTIONS	SCREENSHOT
ready to graduate from the program. **Member is ready to transition to a lower level of care**= Member is ready to be downgraded to a lower level of care management, like CCM. **Complete a direct referral to Molina's CM prior to disenrolling the member from ECM.** **Member no longer wishes to receive ECM or is unwilling to engage**= Member does not want to be in the program or is unwilling to engage. This can include instances when a member's behavior or environment is unsafe for the ECM Provider. If the member no longer wants to be in the program, the ECM LCM is required to mail the Post Opt-In Decline Letter to the member. This can be mailed on the day the member is disenrolled. **ECM provider has been unable to connect with the member after multiple attempts**= Member is unable to be contacted. Also, if you are made aware that a member will be out of the country for longer than 30 days, the member needs to be disenrolled from ECM immediately (do not delay disenrolling the member). However, if you are informed that the	

INSTRUCTIONS	SCREENSHOT
member is out of the country and doesn't know the member's return date, wait 30 days from the date of identification. If the member continues to be out of the country past 30 days, proceed with disenrolling the member. **If the member cannot be contacted, the ECM LCM must mail the ECM Post Opt-In UTC Letter at least a week before planning to disenroll the member to give the member time to receive the letter and call back.** **Member is enrolled in a duplicative program**= Some ECM eligible members may be receiving services from another DHCS-approved program. In some cases, the member may choose to enroll in the ECM, and in some cases, they cannot enroll at all. For a complete list of Duplicative Programs, see the latest ECM Policy Guide. Please note that Molina does not consider MedZed HC 2.0, My Palliative Care, & Major Organ Transplant duplicative programs; ECM members can be enrolled in these programs if services are not duplicative. **Not enrolled with Molina Medi-Cal program**= The member is no longer eligible for Medi-Cal benefits through Molina	

INSTRUCTIONS	SCREENSHOT
Healthcare. Most times, the member leaves our plan and becomes restricted in CCA, if this happens, the ECM LCM is no longer able to submit the Disenrollment Form. **Member passed away**= the member has expired (B) Using the free text field, input additional information based on the reason for the member's disenrollment. For example, if the ECM LCM is unable to mail the Post Opt-In UTC Letter or Post Opt-In Decline Letter to a member due to no address on record, the ECM LCM will indicate this in the "ECM Disenrollment Reason Additional Information" box.	
5. After the form is completed, click save. The screen will then populate with all the member's progress notes, and the Disenrollment Form will be the most recent note. The disenrollment form will automatically route to the Molina ECM Team for processing.	

ECM Checklists

Below are checklists that we put together to give our ECM Providers an idea of the TEL Process, Referral Process, Enrollment Process, Grievance Process, and Disenrollment Process. Please note these checklists do not encompass every single scenario possible and/or additional steps needed. Refer back to our training materials for more information:

TEL Process Checklist

Initial TEL Process

- ☐ ECM Provider will provide TEL parameters to Molina ECM Team, as well as any TEL parameter changes
- ☐ Molina's ECM Team will send a secure email to the ECM Provider with their monthly TEL.

ECM Provider reviews TEL and informs Molina's ECM Team:

- ☐ If there are any discrepancies with the TEL
- ☐ If they are unable to take on any members and need Molina's ECM Team to reassign the members to another ECM Provider

TEL Outreach Process

- ☐ ECM LCM will outreach the members in their TEL **within five business days** from the date of receipt of the TEL
- ☐ ECM LCM checks Availity before outreaching members from their TEL to ensure their members are still eligible with our Plan
- ☐ ECM LCM documents that Availity was checked by entering a Contact Form in CCA. *Purpose of Contact: ECM|Pre-Call Review.*
- ☐ If 1st outreach was successful and the member was enrolled into ECM, refer to the next steps in the *"Enrollment Process Checklist."* A contact form should also be entered in CCA, evidencing completion of the Enrollment Assessment.

Member is UTC & Insufficient Contact Information

- ☐ ECM LCM will complete at least four non-mail attempts and mail the *ECM Generic UTC Letter* (for a total of five attempts). The outreaches should utilize different modes of contact at different times of the day.
- ☐ If the ECM LCM has insufficient member contact information, the ECM LCM will complete a direct referral to Molina's Member Location Unit (MLU). The MLU will inform the ECM Provider via a CCA task within two business days if they find alternate contact information.
- ☐ ECM LCM documents all UTC outreaches by entering a Contact Form(s) in CCA. *Purpose of Contact =ECM|Welcome Contact.* The Outcome of Contact = Left Message, or Disconnected, Invalid Phone #, No Answer, Requested Later Contact
- ☐ If, after exhausting the minimum required attempts, the member continues to be UTC, ECM LCM will complete the ECM Enrollment Assessment in CCA, follow prompts in the screen, and select "**No**" under the question "Did you discuss/confirm eligibility for ECM," and indicate the member was ***Not Enrolled (Unable to Contact)*** and documented the details of the UTC attempt in the Comment's box. A contact form should also be entered in CCA, evidencing completion of the Enrollment Assessment.
- ☐ Suppose the ECM LCM has insufficient contact information to continue outreach efforts. In that case, the ECM LCM will complete the ECM Enrollment Assessment in CCA, follow the prompts on the screen, select "**No**" under the question "Did you discuss/confirm eligibility for ECM," and indicate the member was ***Not Enrolled (Unable to Contact),*** enter "***Yes***" under the question "Is the member unable to contact due to insufficient contact information" and document the details of the UTC outcome in the Comment's box (e.g., wrong phone number, address, etc.). A contact form should also be entered in CCA, evidencing completion of the Enrollment Assessment.

TEL Process Checklist

Member Declines Participation in ECM

- ☐ If the member declines participation in ECM, the ECM LCM will complete ECM Enrollment Assessment in CCA, follow the prompts on the screen, select "**No**" under the question "Did you discuss/confirm eligibility for ECM," and indicate the member ***Declined*** ECM and enter in comment's box member's reason for declining
- ☐ ECM LCM will document the outreach by entering a contact form in CCA. *Purpose of Contact =ECM|Welcome Contact.* The Outcome of Contact = Refused to Speak or Requested No Further Contact. The contact form should also be evidence that the Enrollment Assessment was completed.

Member is deceased

- ☐ If the ECM LCM is informed that the member passed away, the ECM Provider will complete the ECM Enrollment Assessment in CCA, follow the prompts on the screen, select "**No**" under the question "Did you discuss/confirm eligibility for ECM," and indicate the member is ***Deceased.***
- ☐ ECM LCM will document the outreach by entering a Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact.* The Outcome of Contact = Deceased. The contact form should also be evidence that the Enrollment Assessment was completed.

Member meets some pre-identified Populations of Focus.

- ☐ If the member meets some of the pre-identified Populations of Focus, ECM Provider will complete the ECM Enrollment Assessment in CCA, follow the prompts in the screen, select "**Yes**" under the question "Did you discuss/ confirm eligibility for ECM," select "***ECM Eligible***" under the CM Referral Source, and indicate "Yes" under question (s) "Does member meet these criteria?," for the pre-identified Populations of Focus the member meets. For the Populations of Focus the members do not meet, indicate "No" for each "Does member meet these criteria?" pre-identified Population of Focus question(s) the member didn't meet.
- ☐ ECM Provider will document the outreach by entering a Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact.* The outcome of Contact = Successful Contact. The contact form should also be evidence that the Enrollment Assessment was completed.
- ☐ ECM Provider will refer to the next steps in the *"Enrollment Process Checklist."*
- ☐ ECM Provider will provide a list of all the members who were identified to qualify for different Populations of Focus from the pre-identified Populations of Focus to Molina's ECM Team Inbox. Molina's ECM Team will make changes in their system to reflect members' true Population(s) of Focus.

Member does not meet any Population of Focus.

- ☐ If the member does not meet any of the pre-identified Populations of Focus, nor any other Population of Focus, the ECM Provider will inform the member they do not qualify for the ECM Program.
- ☐ ECM Provider will complete the ECM Enrollment Assessment in CCA, follow prompts on the screen, select "**Yes**" under the question "Did you discuss/confirm eligibility for ECM," select "***ECM Eligible***" under the CM Referral Source, and indicate "No" under the question "Does member meet these criteria," for each pre-identified Population of Focus the member didn't meet.
- ☐ ECM Provider will document the outreach by entering a Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact.* The Outcome of Contact = Successful Contact. The contact form should also be evidence that the Enrollment Assessment was completed.
- ☐ If the ECM LCM identifies that the member has care coordination needs, the ECM Provider will answer "Yes" to question "Does the member have outstanding care coordination needs (and you'd like to refer them to Molina's Case Management?." A Molina CM representative will connect with the member.

Member does not meet any pre-identified Population(s) of Focus, but meets other Population(s) of Focus

TEL Process Checklist

- ☐ If the ECM LCM identifies that the member *does not meet any* of the pre-identified Population(s) of Focus but meets other Population(s) of Focus, the ECM LCM will provide a list of all the members who were identified to qualify for different Populations of Focus from the pre-identified Populations of Focus to Molina's ECM Team. Molina's ECM Team will make changes in their system to reflect member's true Population(s) of Focus.
- ☐ After making changes, Molina's ECM Team will inform the ECM LCM to proceed with enrolling the member by completing the Enrollment Assessment in CCA. The ECM LCM will complete the Enrollment Assessment in CCA, follow the prompts on the screen, select "**Yes**" under the question "Did you discuss/confirm eligibility for ECM," select "***ECM Eligible***" under the CM Referral Source, and will indicate "Yes" under the question "Does member meet these criteria," for each identified Population of Focus the member met.
- ☐ ECM LCM will refer to the next steps in the "*Enrollment Process Checklist."*

Member meets some pre-identified Populations of Focus & meets other Population(s) of Focus.

- ☐ If the ECM LCM identifies that the member *meets some* pre-identified Population(s) of Focus and meets other Population(s) of Focus, the ECM Provider will proceed with enrolling the member by completing the ECM Enrollment Assessment in CCA, following prompts on the screen, select "**Yes**" under the question "Did you discuss/confirm eligibility for ECM," select "***ECM Eligible***" under the CM Referral Source, and will indicate "Yes" under question (s) "Does member meet these criteria?," for the pre-identified Populations of Focus the member meets. For the Populations of Focus the members do not meet, indicate "No" for each "Does member meet these criteria?" pre-identified Population of Focus question(s) the member didn't meet.
- ☐ ECM LCM will refer to the next steps in the *"Enrollment Process Checklist."*
- ☐ ECM LCM will provide a list of all the members who were identified to qualify for different Populations of Focus from the pre-identified Populations of Focus to Molina's ECM Team Inbox. Molina's ECM Team will change their system to reflect members' true Population(s) of Focus.

Member is in a duplicative program.

- ☐ If the ECM LCM identifies the member to be in a duplicative program, the ECM LCM will inform the member they do not qualify for the ECM Program.
- ☐ ECM LCM will complete the ECM Enrollment Assessment in CCA, follow the prompts on the screen, select "**Yes**" under the question "Did you discuss/confirm eligibility for ECM," select "***ECM Eligible***" under the CM Referral Source, and indicate "Yes" under the corresponding question the addresses the duplicative program (e.g., state waiver program question, CCT question, hospice question, Molina CM question, etc.). The ECM LCM will also need to enter the name of the duplicative program under the "Describe the duplicative program" question.
- ☐ ECM LCM will document the outreach by entering a Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact.* The Outcome of Contact = Successful Contact. The contact form should also be evidence that the Enrollment Assessment was completed.

Note: If a member is UTC or declines participation into ECM, a Disenrollment must not be completed.

Enrollment Process Checklist

Enrollment into ECM (Successful Engagement)

Pre-enrollment (TEL Members)

- ☐ ECM Provider successfully outreaches their TEL member, confirms member qualifies for ECM, agrees to enroll in ECM, and provides verbal agreement for data sharing.
- ☐ ECM Provider enrolls the member by completing the ECM Enrollment Assessment in CCA
- ☐ ECM Provider assigns an ECM Lead Care Manager (LCM) to the member within **five business days** of enrolling a member
- ☐ ECM Provider and member agree on a follow-up date to complete the HRA and develop the care plan *(Best Practice: Complete the HRA within three business days from enrolling a member and complete the care plan within two business days of HRA completion, but no later than 90 days from enrollment date)*
- ☐ ECM Provider documents enrollment outreach via the Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact*

Pre-enrollment (Referred Members)

- ☐ Molina ECM Team will refer members to the ECM Provider and will request that the ECM Provider enroll the referred member via the ECM Enrollment Assessment in CCA within 24 hours.
- ☐ ECM Provider assigns an ECM Lead Care Manager (LCM) to the member within **five business days** of enrolling a member
- ☐ ECM Provider documents enrollment via the Contact Form in CCA. *Purpose of Contact =ECM|Welcome Contact*
- ☐ ECM LCM outreaches members within ***five business days*** of enrolling the member (1st outreach)

Post-enrollment (All Enrolled Members)

- ☐ Molina will automatically mail the ECM Notification Letter to the member's PCP after a member has been opted-in
- ☐ ECM Provider will review the Daily Enrollment Report (outbound by Molina via the sftp site) to reconcile that the member was enrolled
- ☐ ECM Provider will review the Weekly Member Activity Report (outbound by Molina via the sftp site). Enrolled members should also appear in this report.
- ☐ ECM LCM mails the Welcome Letter to the member within **three business days** of enrolling the member and documents that the letter was mailed to the member via the Contact Form in CCA. Purpose of Contact =*ECM|Welcome Contact*
- ☐ Within **five business days** of assigning an ECM LCM to the member, the ECM LCM documents their credentials and confirmation of their expertise and skills to serve the individual member in a culturally relevant, linguistically appropriate, and person-centered manner post-enrollment via the Contact Form in CCA.

Post-enrollment (HRA & Care Plan)

- ☐ ECM LCM checks Availity prior to engaging the member to ensure member is still eligible with our Plan
- ☐ ECM LCM conducts pre-call review by viewing data available in CCA and the Member Dashboard prior to engaging the member
- ☐ ECM LCM documents that Availity was checked and that the pre-call review was completed via the Contact Form in CCA. Purpose of Contact: ECM|Pre-Call Review
- ☐ ECM LCM completes the HRA with the member, determines member's acuity, and develops the care plan *(no later than 90 days from enrollment date)*
- ☐ ECM LCM completes condition-specific assessments (if applicable) with the member and documents completion of the assessment(s) via the Contact Form in CCA
- ☐ Main health concern is incorporated into ECM care plan as Main Case Name (i.e. *ECM- Diabetes*) and all other active concerns as identified in the HRA including Behavioral health and community based supportive services, i.e. LTSS. ECM LCM will also update the care plan based on outcome(s) of condition-specific assessments.
  - ☐ Goals should be written in SMART format with all outcomes measurable and prioritized
  - ☐ ECM care plan contains Problem, Goal, Intervention, Outcome, and Barrier
  - ☐ ECM LCM conducts ICT with Clinical Consultant and discusses the member's CA-HRA and care plan. The Clinical Consultant provides input (as needed). ECM LCM documents on behalf of the Clinical Consultant their review via the Contact Form in CCA.
  - ☐ ECM LCM **is required to obtain member consent** when developing the care plan and anytime the care plan is updated. This should always be documented in CCA's Care Plan and Contact Form.

Enrollment Process Checklist

Enrollment into ECM (Successful Engagement)

- ☐ ECM LCM will mail a copy of the Care Plan and ECM Care Plan letter to the member, as well as provide a copy of the care plan to the member's PCP along with the PCP ECM Care Plan letter *within 90 days of enrolling the* member *(Best Practice: within three business days of completing the care plan)*
- ☐ ECM LCM documents the completion of the CA-HRA, discussion of care plan goals with the member, and notes member consent was obtained via the Contact Form in CCA. Purpose of Contact *=ECM|Assessment|Care Plan Development / Revision (if both the HRA and Care Plan were completed on the same day)*
- ☐ Depending on member needs, the ECM LCM should also administer condition-specific assessments. If the PHQ-9 or PTSD 5 assessments were administered, the ECM LCM will need to mail Molina's ECM PHQ-9 PCP Notification Letter and PTSD 5 PCP Letter to the member's PCP. These letters are not found in CCA. Molina's ECM Team has provided the templates.
- ☐ ECM LCM will set a reminder to complete the HRA Reassessment within six months from the initial HRA completion date. ECM LCM sets reminders to follow up with the member to continue to provide ECM services every month
- ☐ If a member requested the Advance Directives booklet during the completion of the CA-HRA and never received the information or if the member needs to read the booklet in a different language **-** Task Janna Hamilton for "5 wishes" in CCA

Post-enrollment (Post Completion of Initial HRA & Care Plan)

- ☐ ECM LCMs will engage members every month and provide ECM services; this includes educating/coaching the member and utilizing Healthwise Knowledge Base (available in CCA)
- ☐ ECM LCM will refer members to services such as community support services, LTSS, IHSS, etc., as applicable
- ☐ ECM LCM will continue to check Availity before engaging the member to ensure the member is still eligible with our Plan
- ☐ ECM LCM will continue to conduct pre-call reviews by viewing data available in CCA and Member Dashboard before engaging the member. This will help detect new patterns of care.
- ☐ ECM LCM will continue to document that Availity was checked and that the pre-call review was completed via the Contact Form in CCA. Purpose of Contact: ECM|Pre-Call Review
- ☐ ECM Provider will continue to report all outreaches (regardless of outcome) via the Contact Form in CCA and clearly note the outcome of the contact
- ☐ ECM Provider will continue to update the care plan with the member. The care plan must be updated every six (6) months at a minimum from the last update or more frequently upon changes in the member's health status or condition.
- ☐ ECM Provider will continue to administer CA HRAs (reassessments), condition-specific assessments (as needed), and Transitions of Care Assessments
- ☐ ECM Provider will review the Weekly Member Activity Report (outbound by Molina via the sftp site) as part of their oversight and monitoring activities. Molina recommends that our ECM Providers conduct internal audits to ensure compliance with Molina/Regulatory requirements.
- ☐ Any member with low acuity and/or well-managed should be reassessed for program graduation or referred to Molina CM for a lower level of care.

Case Conferences (ICT Meetings)

- ☐ ECM LCM will conduct and participate in case conferences to help ensure that the member's care is continuous and integrated among all service providers. A case conference will need to occur within 60 days of identified need, dependent on the acuity of the situation.
- ☐ ECM LCM will report all ICT meetings via the Contact Form in CCA. *Purpose of Contact: ECM|ICT Meeting*

NAL & BH Crisis Follow-Ups

- ☐ Molina ECM Team will inform ECM Providers if we identify a member who called the Nurse Advise Line (NAL) or the BH Crisis Line.
- ☐ ECM LCM will need to follow up with the member within 24-48 hours from the date of notification and assist the member with any care coordination needs
- ☐ ECM Provider will document outreach via the Contact Form in CCA:
    - *Purpose of Contact =ECM|Follow-up* (for NAL follow-up)
    - *Purpose of Contact= ECM| BH Crisis Call Follow-Up* (for BH Crisis Follow-up)

Enrollment Process Checklist

Enrollment into ECM (Successful Engagement)

Transitions of Care

- ☐ ECM Provider will review the Daily IP Census Report (outbound by Molina via the sftp site) for any members who have been hospitalized or in an SNF. The report will include TEL members and members who have been enrolled in ECM. *For TEL members, use this report to outreach members in the hospital/SNF for enrollment into ECM.*
- ☐ When available, Molina ECM Team will also notify the ECM Provider if a member has been hospitalized.
- ☐ ECM LCM must use all tools at their disposal to identify and interact with recently admitted/discharged members
- ☐ ECM LCM will follow up with the member via telephone within two business days of discharge to ensure any follow-up care needs are met, including assisting with scheduling needed follow-up appointments with PCP/Specialist.
- ☐ ECM LCM will conduct a face-to-face visit within seven business days from discharge to determine the member's post-inpatient status and any further care needs and complete the Transition of Care assessment
- ☐ ECM LCM is expected to collaborate, communicate, and coordinate with all involved parties.
- ☐ ECM LCM will complete a new HRA with the member, and the care plan should be updated post-discharge to address hospitalization and measures to prevent readmission. ECM LCM should discuss the updated care plan with their clinical consultant for input (as needed)
- ☐ ECM Provider will report completed a new CA-HRA (*HRA Reassessment)*
- ☐ ECM LCM will discuss the updated care plan with the member and obtain the member's consent
- ☐ ECM LCM will mail a copy of the revised Care Plan and ECM Care Plan letter to the member, as well as provide a copy of the revised care plan to the member's PCP along with the PCP ECM Care Plan letter within 14 business days of updating the care plan *(Best Practice: 3 business days of updating the care plan)*
- ☐ For Homeless members, the ECM Providers should plan an appropriate place for the member to stay post-discharge from the hospital or SNF, including temporary or permanent housing, and explore Community Supports referrals.
- ☐ ECM LCM will complete a Transitions of Care (TOC) Assessment with the member within seven business days after the member has been discharged from the hospital/SNF.
- ☐ ECM Provider will document all TOC-related outreaches via the Contact Form in CCA. *Purpose of Contact: ECM|Post Discharge Outreach| Assessment|Care Plan Development/ Revision|Coordination of Services*

HRA Reassessments

- ☐ ECM LCM will complete a new CA-HRA (HRA Reassessment) within six months from the initial CA-HRA completion date (& every six months thereafter). Members might require a new CA-HRA to be completed sooner if they are hospitalized.
- ☐ ECM LCM will revise the care plan if there's a change in a member's condition and discuss the updated care plan with their clinical consultant for input (as needed).
- ☐ ECM LCM will discuss the updated care plan with the member and obtain the member's consent.
- ☐ ECM LCM will mail a copy of the revised Care Plan and ECM Care Plan letter to the member, as well as provide a copy of the revised care plan to the member's PCP along with the PCP ECM Care Plan letter within 14 business days of updating the care plan *(Best Practice: 3 business days of updating the care plan).*
- ☐ ECM Provider will document all HRA and Care Plan outreaches via the Contact Form in CCA. *Purpose of Contact: ECM| Assessment|Care Plan Development/ Revision.*

Medi-Cal SPD Members

- ☐ If an existing Medi-Cal member changes product lines and is designated as "Seniors and Persons with Disabilities (SPD)," a new HRA must be completed within 30 days of the member's enrollment as SPD. The Molina ECM Team will send reminders as the due date approaches.
- ☐ ECM LCM will follow the same steps for completing the CA-HRA and updating the care plan

Grievance Process Checklist

A complaint (or grievance) is when a member has a problem with Molina Healthcare or a provider or the health care or treatment they received from a provider. The member has the right to file a grievance with Molina Healthcare to tell us about their problem. When identifying such problems, the ECM LCM should encourage the member to file a grievance and assist the member in filing the grievance.

Grievance Process
☐ If an ECM member has a complaint/grievance, the ECM LCM should educate/assist the member with filing the grievance (please act on this as soon as you identify it). ☐ For more information on filing a grievance, please review the latest Member Handbook on the Molina Website. The 2023 Member Handbook is located below: https://www.molinahealthcare.com/members/ca/en-us/-/media/Molina/PublicWebsite/PDF/members/ca/en-us/Medi-Cal/2023-English-Spanish-EOC.pdf
☐ Member services will route the grievance to the Appeals & Grievance Team. ☐ The Appeals & Grievance Team will review and route the grievance to Molina's ECM Team to request information. ☐ Molina's ECM Team will provide member's assigned ECM LCM contact information to the Appeals & Grievance Team (based on ECM LCM information entered in the CCA Address Book) ☐ Molina's ECM Team will route the *Grievance Response Form* to the assigned ECM Provider and give them 48-72 hours to respond to the questions in the form. *Keep in mind even if the grievance is not against the ECM Provider, the Appeals & Grievance Team will still want to gather information from the assigned ECM Provider.*
☐ Depending on the grievance, the ECM LCM might need to make another outreach to the member and document the outcome in CCA via the contact form. ☐ ECM Provider will submit their completed Grievance Response Form to Molina's ECM Team.
☐ Molina's ECM Team will review the Grievance Response Form and route it to the Appeals & Grievance Team.
☐ The Appeals & Grievance Team will review and might ask for updates and/or additional information. ☐ The Appeals & Grievance Team might also contact the assigned ECM LCM for information.
☐ Molina's ECM Team will contact the ECM Provider and request an update and/or additional information. ☐ The requested information will be routed to the Appeals & Grievance Team.
☐ The Appeals & Grievance Team will mail a resolution letter to the member and include the assigned ECM LCM's contact information.

Disenrollment Process Checklist

ECM LCMs should only disenroll members enrolled in ECM and ready to be disenrolled from the program. A disenrollment is not needed for TEL members who declined ECM or are UTC.

Disenrollment Process
UTC Members (Non-homeless PoF Members) ☐ For members who do not fall under the homeless Population of Focus and the ECM LCM has exhausted the minimum required outreach attempts (3 non-mail attempts and mailing the *ECM Post Opt-In UTC Letter*) within a month, the ECM LCM will proceed with disenrolling the member from the program by completing the Disenrollment Form in CCA and indicating disenrollment reason: *ECM LCM has been unable to connect with the member after multiple attempts.* The member will need to be disenrolled no later than the last day of the month. ☐ After mailing the *ECM Post Opt-In UTC Letter to the member,* the ECM LCM should *wait a couple of days (recommend waiting about one week)* to allow time for the member to receive the letter and reach out to their ECM LCM. *Do not mail the letter on the same day you are disenrolling the member*. If the member continues to be UTC within a week of mailing the letter, the ECM LCM should proceed with disenrolling the member from ECM. ☐ If the ECM LCM is unable to mail the letter to the member due to no address on record or wrong address, the ECM LCM will need to document this information in the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form. ☐ ECM LCM will document all UTC outreaches via the Contact Form in CCA. The Outcome of Contact = Left Message, Disconnected, Invalid Phone #, No Answer, Requested Later Contact. The Outcome of Contact for mailing letter=Other.The Outcome of Contact Other: Mailed Letter ☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:* *Exhausted non-mail attempts, mailed ECM Post Opt-In UTC Letter* ☐ ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.
UTC Members (Homeless PoF Members) ☐ For members who fall under the homeless Population of Focus, the ECM LCM will complete two months' worth of attempts; this includes four non-mail attempts and mailing the *ECM Post Opt-In UTC Letter* to the address on record (in CCA) during month one and then if the member continues to be UTC, extend those attempts to the 2nd month (3 additional non-mail attempts and mailing the *ECM Post Opt-In UTC Letter).* If the member continues to be UTC by the end of the 2nd month, the ECM LCM will proceed with disenrolling the member from the program by completing the Disenrollment Form in CCA and indicating the disenrollment reason: *ECM LCM has been unable to connect with the member after multiple attempts.* The member will need to be disenrolled no later than the last day of the 2nd month. ☐ After mailing the *ECM Post Opt-In UTC Letter to the member,* the ECM LCM should *wait a couple of days (recommend waiting about one week)* to allow time for the member to receive the letter and reach out to their ECM LCM. Do not mail the letter on the same day you are disenrolling the member. If the member continues to be UTC within a week of mailing the letter, the ECM LCM should proceed with disenrolling the member from ECM no later than the last day of the month. ☐ ECM LCM will document all outreaches via the Contact Form in CCA. The Outcome of Contact = Left Message, Disconnected, Invalid Phone #, No Answer, Requested Later Contact. The Outcome of Contact for mailing letter=Other. The Outcome of Contact Other: Mailed Letter ☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:* *Exhausted non-mail attempts, mailed ECM Post Opt-In UTC Letter* ☐ ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.
Member who declined ECM ☐ For members who no longer wish to be in the ECM Program, the ECM LCM will proceed with disenrolling the member from the program by completing the *Disenrollment Template* and indicating disenrollment reason: *Member no longer*

Disenrollment Process
wishes to receive ECM or is unwilling to engage. ECM LCM should not delay disenrolling the member from ECM if the member declines ECM. ECM LCM is to use the decline date as the date of disenrollment in the Disenrollment Form in CCA. ☐ ECM LCM will mail the Post Opt-In Decline letter to the member before disenrolling the member from ECM. If the ECM LCM is unable to mail the Post Opt-In Decline Letter to a member due to no address on record or the wrong address, the ECM LCM will indicate this in the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form. ☐ ECM LCM will document the outcome of the member discussion (member declined ECM) via the Contact Form in CCA, in addition to documenting (separately) that the Post Opt-In Decline Letter was mailed to the member. The Outcome of Contact = Requested No Further Contact. The Outcome of Contact for mailing letter=Other. The Outcome of Contact Other: Mailed Letter ☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:* *Member declined ECM, mailed ECM Post Opt-In Decline Letter* ☐ ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.
Member who met all care goals ☐ For members who are ready to graduate from the ECM Program because they are well-managing their conditions and have met all their care plan goals, the ECM LCM will proceed with disenrolling the member from the program by completing the Disenrollment Form in CCA and indicating disenrollment reason: *All care goals are met.* ☐ ECM LCM will document the outcome of member discussion (ECM LCM informing the member they are graduating from the ECM Program) via the *Contact Form Template.* ☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:* *Member is ready to graduate. Discussed with the member, and the member agreed.* ☐ ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.
Member is ready to transition to a lower level of care ☐ If the ECM LCM identifies that the member is ready to be downgraded to a lower level of care management (Molina CM), the ECM LCM will proceed with disenrolling the member from the ECM Program by completing the *Disenrollment Template* and indicating disenrollment reason: *Member is ready to transition to a lower level of care* ☐ ECM LCM will document the outcome of the member discussion (ECM LCM informing the member they are being referred to Molina's CM and are being disenrolled from the ECM Program) via the *Contact Form in CCA.* ☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:* *Completed direct referral to Molina's CM* ☐ ECM LCM will complete the Direct Referral to Molina CM in CCA before disenrolling the member ☐ ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.
Member is enrolled in a duplicative program. ☐ If the ECM LCM identifies that the member is in a duplicative program (e.g., hospice, CCM, MSSP, etc.), the ECM LCM will proceed with disenrolling the member from the ECM Program by completing the Disenrollment Form in CCA and indicating disenrollment reason: *Member is enrolled in a duplicative program.* ☐ ECM LCM will document the outcome of member discussion (ECM LCM informing the member they are being disenrolled from the ECM Program because they are already receiving the same care management services through another program) via the Contact Form in CCA. ☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:* *Member in CCM and requested to opt-out of ECM*

Disenrollment Process
☐ ECM LCM will close the member's milestones, ECM care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.
Member not enrolled in Molina Medi-Cal Program. ☐ If the ECM LCM identifies that the member has lost eligibility with Molina Medi-Cal Program (reviewed Availity or member informed ECM LCM), the ECM LCM will proceed with disenrolling the member from the ECM Program by completing the Disenrollment Form in CCA and indicating disenrollment reason: *Not enrolled with Molina Medi-Cal program.* ☐ ECM LCM will document the outcome of member discussion (ECM LCM informing the member they are being disenrolled from the ECM Program because they are no longer in the Molina Medi-Cal Program) via the Contact Form in CCA. ☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:* *Member lost eligibility with Molina* ☐ ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.
Member passed away. ☐ If the ECM LCM identifies that the member has passed away, the ECM LCM will proceed with disenrolling the member from the ECM Program by completing the *Disenrollment Form in CCA* and indicating the disenrollment reason: *Member passed away.* ☐ ECM LCM will document the outcome of the discussion with the individual who informed ECM LCM that the member passed away (e.g., member's family or friend) via the Contact Form in CCA. ☐ ECM LCM will complete the "ECM Disenrollment Reason Additional Information" box under the Disenrollment Form*; see the example below:* *Informed by the member's sister, Jane Smith, that member passed away on 9/1/2022* ☐ ECM LCM will close the member's milestones, care plan, and pending tasks, remove their contact information from the Address Book, and remove themselves from the Assignments.
Note ☐ Once a member is disenrolled from the ECM Program, the member becomes restricted in CCA, and you can no longer access the member's profile. ☐ An ECM Enrollment Assessment does not need to be completed after disenrolling a member.
Returning Members If the member returns your call after they have been disenrolled from ECM and wishes to continue with the ECM Program, the member will need to be re-enrolled. Please complete a Molina ECM Referral Form and submit it to Molina's ECM Team: MHC_ECM@MolinaHealthCare.Com. Molina's ECM Team will contact you with the next steps.

Molina ECM Reports

Below is a list of all the reports that Molina's ECM Team provides to our ECM Providers. ECM Providers are expected to review these reports. If you encounter any discrepancies with any of these reports, please notify Molina's ECM Team immediately: MHC_ECM@MolinaHealthCare.Com

Report	Description	Format	Method of Distribution	Frequency
TEL Eligibility File (aka MIF)	List of ECM Eligible members assigned to each ECM Provider. For use in outreach and enrollment.	Excel file	Manually via secure email	Monthly
Daily Enrollment Report	List of newly opted-in ECM members	Excel file	sFTP	Daily
Member Activity Report	Post opt-in ECM activity by the member. Includes most recent contact date; HRA completion date; ICP due date; assigned ECM Lead CM. Refer to the report for all fields. ECM Providers must review this report as part of their oversight and monitoring activities and reconcile against capitation reports.	Excel file	sFTP	Weekly
IP Census Report	ECM Eligible & Opt-in members who are currently inpatient (Hospital & SNF). Utilize this report in addition to an email notification from Molina for transition of care (ToC) activities	Excel file	sFTP	Daily
Monthly Capitation Details	Cap reports with member details are available through the	Excel	FES	Monthly

	Financial Exchange Services (FES) portal. Reports are available within one day of the capitation payment being generated.			

Note: Reports may have a time lag of one or two business days due to the overnight update process.

ECM Payment Information

The File Exchange Services (FES) Portal provides capitation payment reports with member-level details available through the FES portal. Reports are available within one day of the capitation payment being generated.

If your organization needs access to FES, please email the name, organization, and email of each person requesting FES access to the ECM team: MHC_ECM@MolinaHealthcare.com. We recommend each organization requests access for at least two employees: one person from your Finance/Accounting Department and one person from your ECM team. Upon being granted access, users will receive an email with the FES login and password. Access FES at the following link: https://fes.molinahealthcare.com/FES/login. For password resets or login information, email the Molina EDI team at the following mailbox: edi.encounters@molinahealthcare.com. We recommend using the EDI email address to report issues rather than the phone number on the portal, as the email has a faster response time. Note that if you contract with Molina for lines of business other than ECM (e.g., Medi-Cal, Medicare, Marketplace), you will need two different logins: one for ECM and one for all other lines of business.

INSTRUCTIONS

Step 1: Upload File

After logging into the FES portal, click on the Upload File header. The upload file page will be displayed.

Below fields should be displayed.

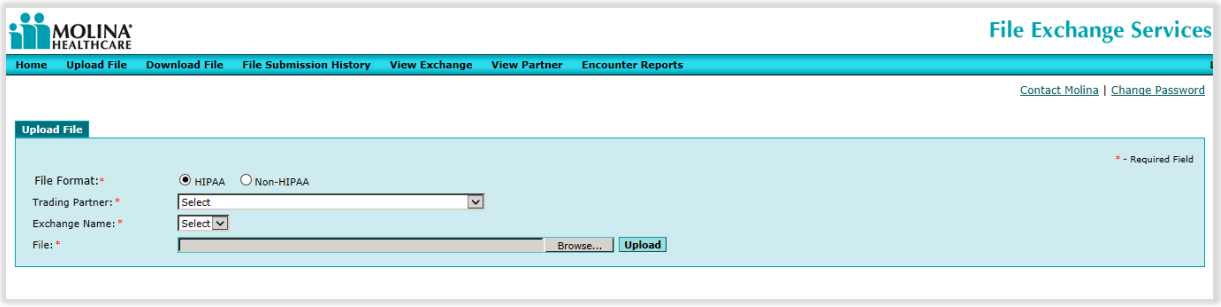
•File Format

•Trading Partner

•Exchange Name

•File to be uploaded.

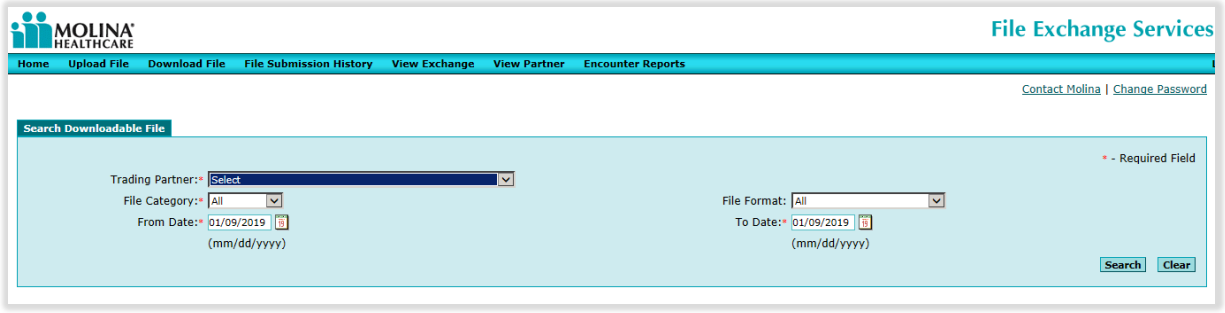
Select the file format, Trading Partner and Exchange Name. Then select the file to be uploaded and click on upload.



Step 2: Download File

Below page will be displayed upon clicking on the Download File option.

INSTRUCTIONS



Below fields should be displayed.

•Trading Partner

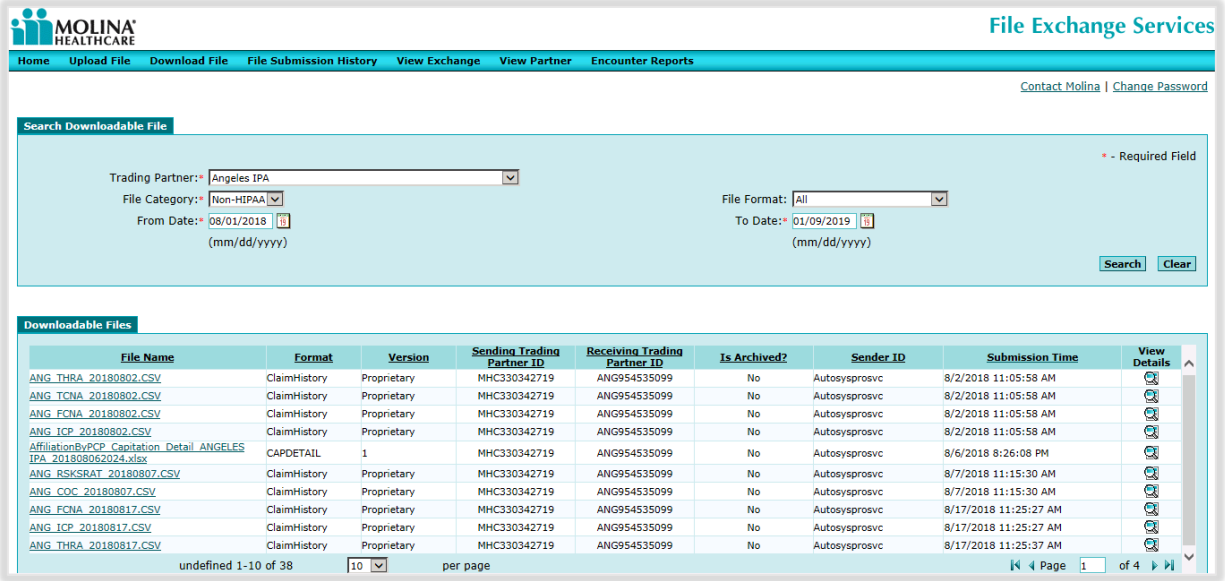
•File Category

•File Format

•From Date

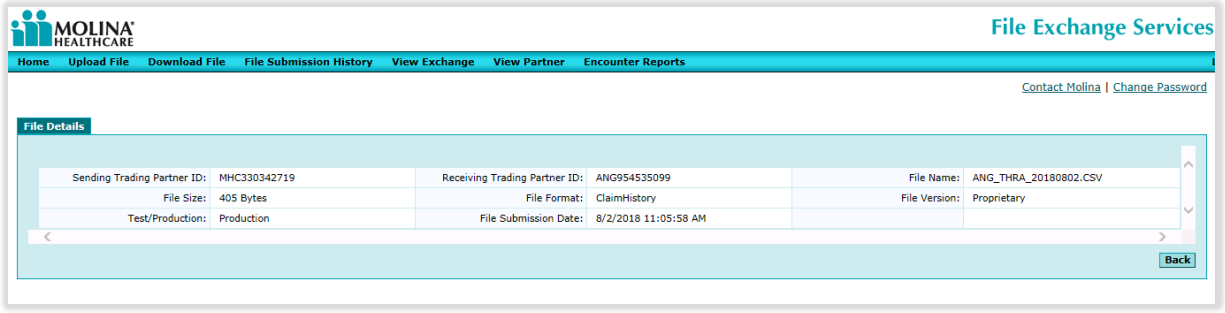
•To Date

Enter all mandatory fields and click on search. Files related to search criteria should be displayed.



Click on the View Details icon in the last grid of each file to view file details.

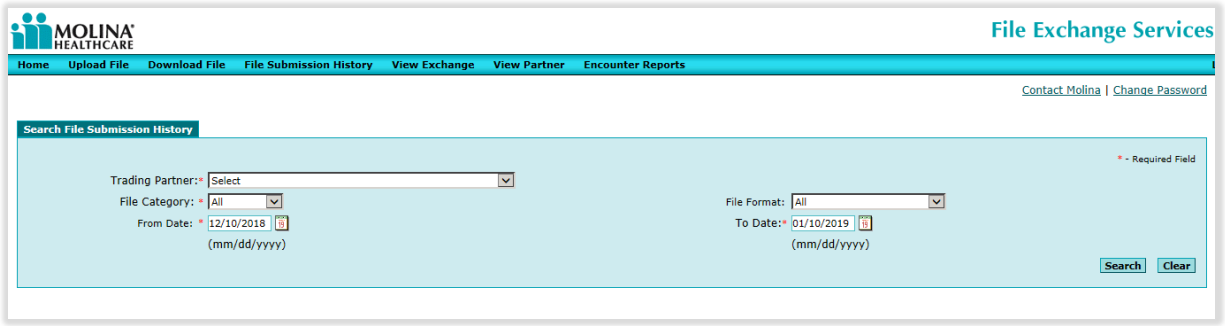
INSTRUCTIONS



Click on the file name link to open or save the files.

Step 3: File Submission History

Below page will be displayed upon clicking on the File Submission History option.



Below fields should be displayed.

•Trading Partner

•File Category

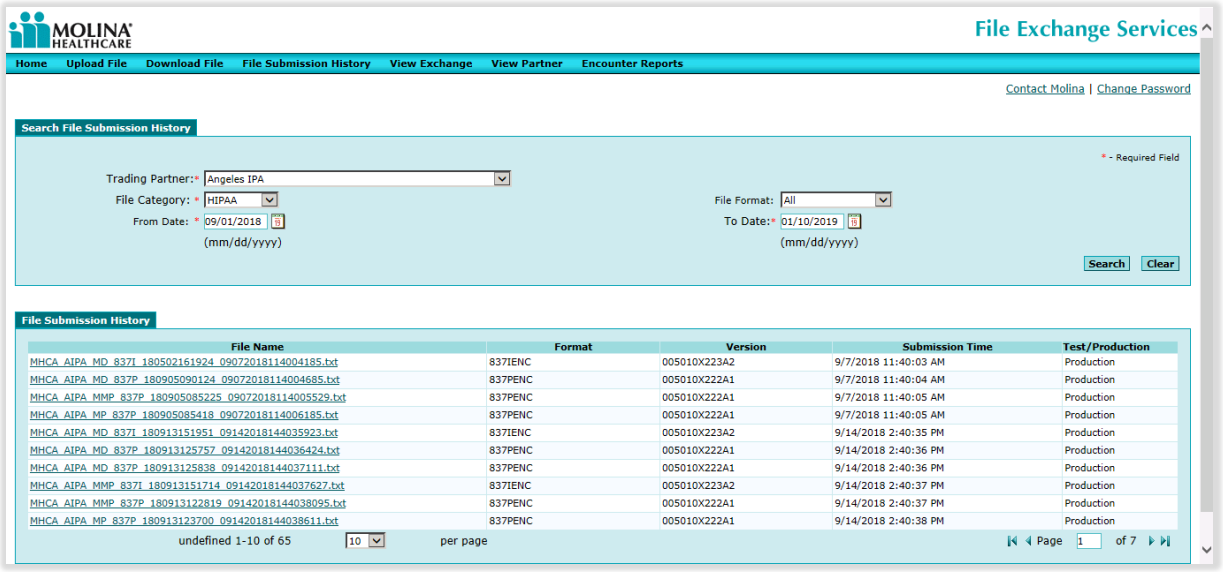
•File Format

•From Date

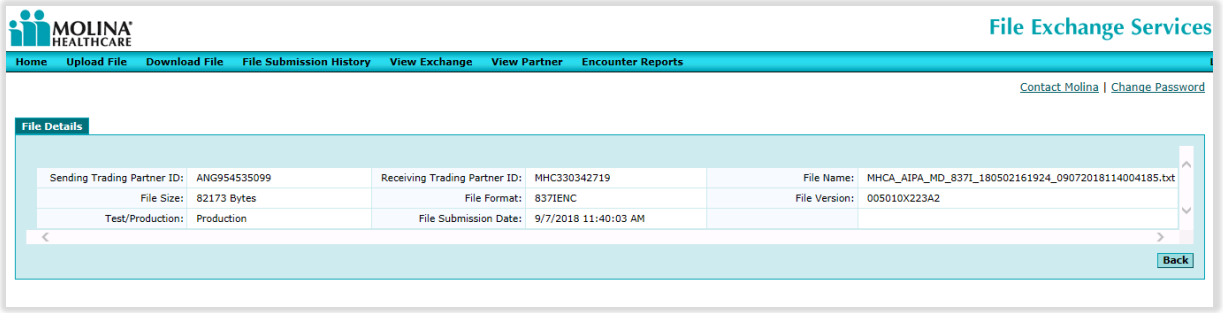
•To Date

Enter all mandatory fields and click on search. Files related to search criteria should be displayed.

INSTRUCTIONS

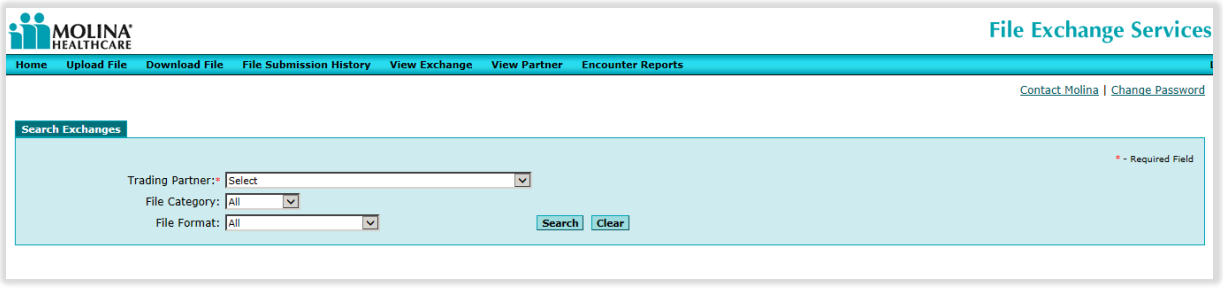


Click on the file name link to file details.



Step 4: View Exchange

Below page will be displayed upon clicking on the View Exchange option.



Below fields should be displayed.

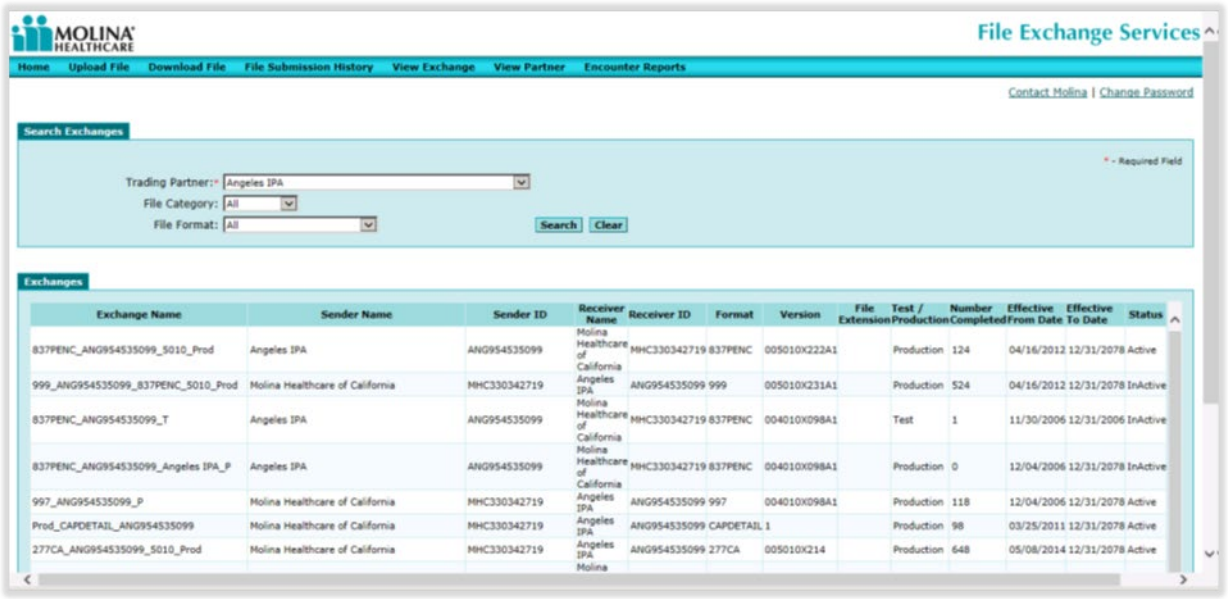
•Trading Partner

INSTRUCTIONS

•File Category

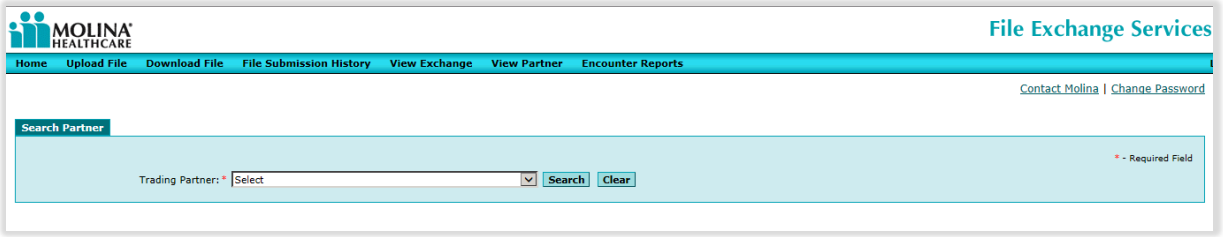
•File Format

Select the required fields and click on search. Search results will be displayed for the search fields entered.



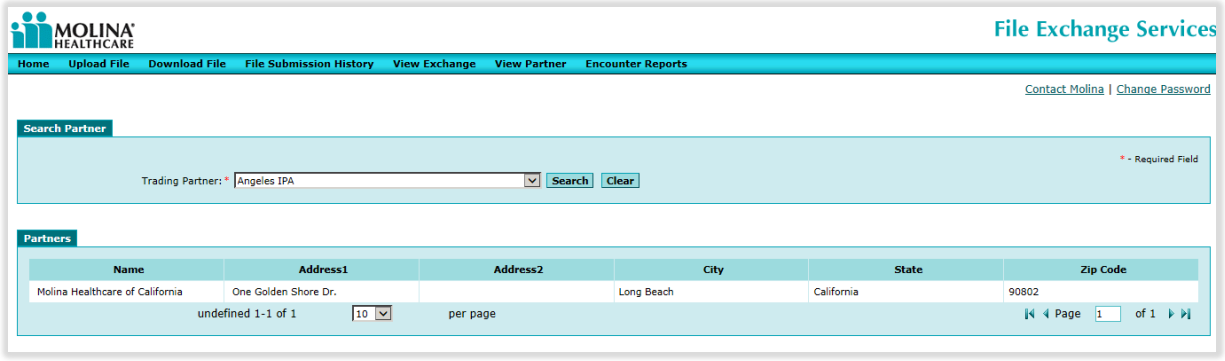
Step 5: View Partner

Below page will be displayed upon clicking on the View Partner option.



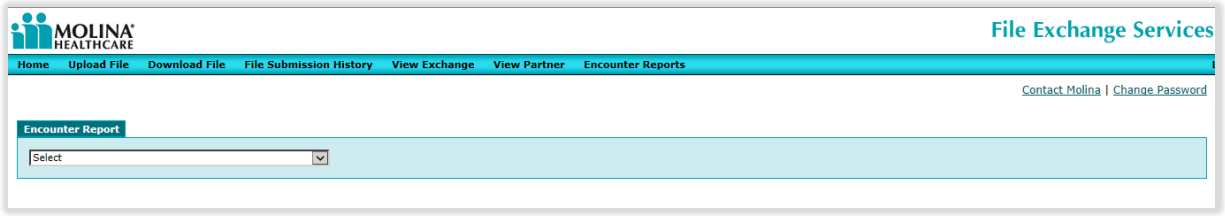
Select Trading Partner from the list and click on search. Search results will be displayed for the search fields entered.

INSTRUCTIONS



Step 6: Encounter Report

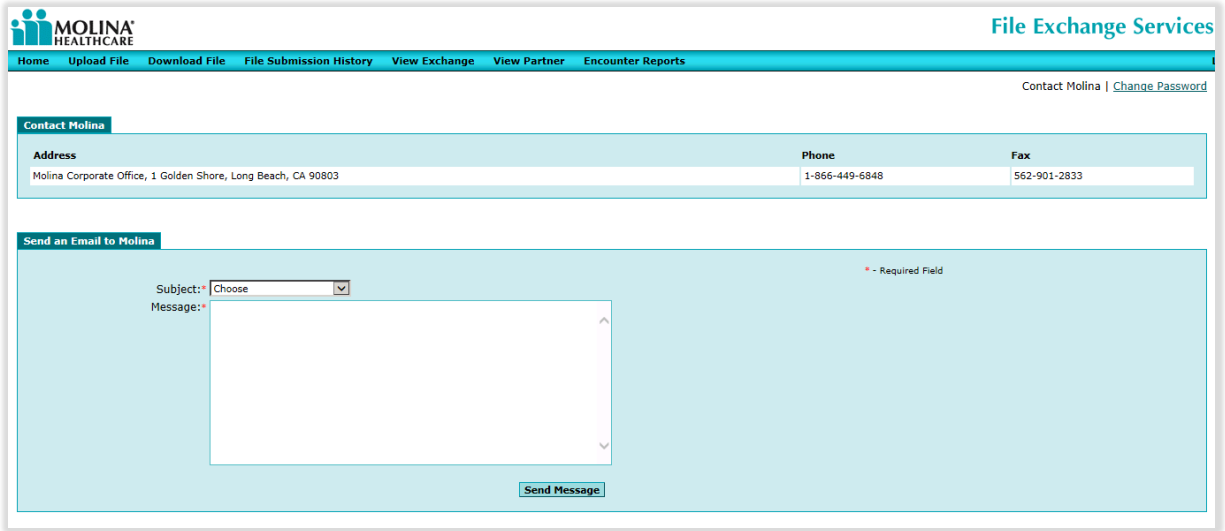
Below page will be displayed upon clicking on the Encounter Report option.



Select an option from the list. Reports will be displayed for the selection.

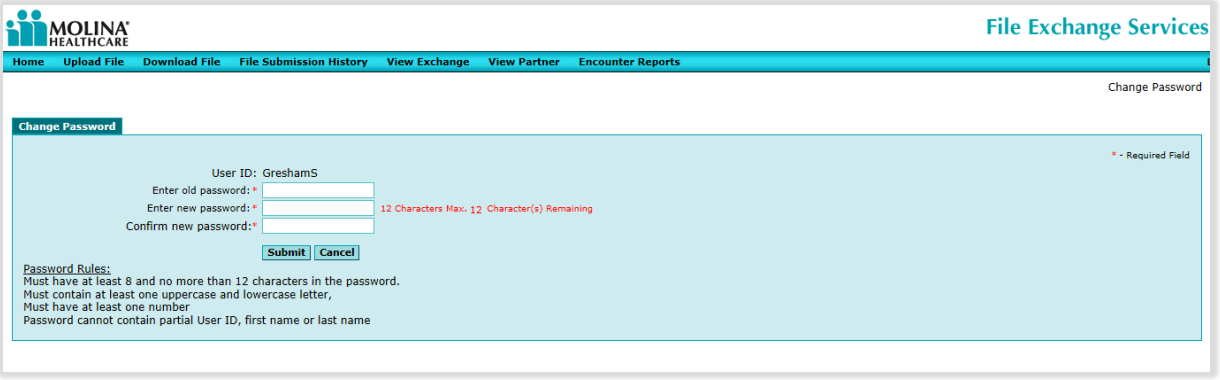
Step 7: Contact Molina and Change the Password

Contact Molina page will be displayed when the user clicks on the link.



Change Password page will be displayed when the user clicks on the link.

INSTRUCTIONS



ECM Provider Resource Guides

All Regions

Department	Telephone Number	Email/Web Link	Hours of Operation
Member Services	1-888-665-4621 (TTY 711)		Available Monday-Friday, 7:00 am - 7:00 pm
Transportation Vendor: American Logistics What if a member is unable to be transported to a medical appointment by ordinary means of public or private conveyance (such as but not limited to taxi or car) due to their medical/physical condition? A: Call American Logistics to arrange transportation and, if needed, provide the MD with the Physician Certification Statement Form (PSF) to complete and submit. The form is not a Prior Auth request form and is not needed to arrange transportation.	1-855-944-1370 PCS Form: https://www.molinahealthcare.com/providers/ca/medicaid/forms/~/media/Molina/PublicWebsite/PDF/Providers/ca/Medical/Physician-Certification-Statement.pdf	**Urgent same-day request:** Molina_support@americanlogistics.com in an individual email with "Urgent – Same Day Request" in the subject line so that it can be entered immediately.	Available Monday-Friday, 7:00 am - 7:00 pm Urgent Appointments only: Available 24 hours a day, 7 days a week. *A minimum of three (3) business day notice is required. Urgent/same-day requests are not guaranteed.

All Regions

Department	Telephone Number	Email/Web Link	Hours of Operation
Interpreter Services *(processed through Member Services)*	1-888-665-4621 (TTY 711)		Available Monday-Friday, 7:00 am - 7:00 pm
Nurse Advise Line	1-888-275-8750 (English) 1-866-648-3537 (Spanish)		Registered nurses are available 24 hours a day, 7 days a week.
Molina Help Finder		https://molinahelpfinder.com	Molina Help Finder is an online community resource directory for community based organizations and government resources. Access, search, seek, assess, and refer to thousands of programs, community-based resources, and services in every zip code in the United States Available 24 hours a day, 7 days a week.
Molina Healthcare Provider Directory	1-888-665-4621 (TTY 711)	www.MolinaHealthcare.com	The Provider Directory has names, provider addresses, phone numbers, business hours, and languages spoken. It tells if the provider is taking new patients. It gives the level of physical accessibility for the building.
Denti-Cal (for dental services)	1-800-322-6384	https://www.denti-cal.ca.gov/find-a-dentist/home	Available Monday-Friday from 8:00 am-5:00 pm

All Regions

Department	Telephone Number	Email/Web Link	Hours of Operation
Pharmacy **As of January 1, 2022, Medi-Cal Rx will be responsible to review and authorize Medications** Medi-Cal Rx Website: www.Medi-CalRx.dhcs.ca.gov MRx Pharmacy Locator: https://medi-calrx.dhcs.ca.gov/home/find-a-pharmacy Meds: https://medi-calrx.dhcs.ca.gov/home/cdl	Outpatient Prescription Medications have been carved out to the State and are no longer managed by the Health Plans	**How to access the Rx Portal and obtain access:** Visit https://medi-calrx.dhcs.ca.gov/home/education For Provider Portal registration assistance and training email: MediCalRxEducationOutreach@magellanhealth.com	Medi-Cal Rx Customer Service Center line 1-800-977-2273, 24 hours a day, 7 days a week, 711 for TTY, Monday to Friday, 8:00 am to 5:00 pm

LA County

Department	Telephone Number	Email/Web Link	Hours of Operation
Health Net Member Services is responsible for Eligibility, Transportation, Interpreter, PCP change, Medical Group change, Benefit inquiries, Grievances, and Appeals)	1-800-675-6110 TTY: 1-800-431-0964 or 711		Available 24 hours a day 7 days a week
Transportation American Logistics	1-800-675-6110 TTY: 1-800-431-0964 or 711		Available Monday-Friday, 7 a.m.–7 p.m. *A minimum of three (3) business day notice is required. Urgent/same-day requests are not guaranteed.
Interpreter Services	1-800-675-6110		Available 24 hours a day 7 days a week
Nurse Advice Line	1-888-275-8750 (English) 1-866-648-3537 (Spanish)		Registered nurses are available 24 hours a day, 7 days a week.
BH (Mild to Moderate)	Call Molina Call Center (888) 665-4621		Available Monday-Friday 7 a.m.–7 p.m.
BH SMI (Severe Mental Illness)	800-854-7771 ACCESS		Available 24 hours a day 7 days a week
Mental Health Urgent Care		http://www.dhcs.ca.gov/individuals/pages/mhpcontactlist.aspx	Reference the Mental Health Plans toll-free telephone number available 24 hours a day, 7 days a week.
Substance use Disorder	844-804-7500		

LA County

Department	Telephone Number	Email/Web Link	Hours of Operation
Molina Healthcare Provider Directory	1-888-665-4621 (TTY 711)	www.MolinaHealthcare.com	The Provider Directory has names, provider addresses, phone numbers, business hours, and languages spoken. It tells if the provider is taking new patients. It gives the level of physical accessibility for the building.
Molina Help Finder		https://molinahelpfinder.com	Molina Help Finder is an online community resource directory for community-based organizations and government resources. Access, search, seek, assess, and refer to thousands of programs, community-based resources, and services in every zip code in the United States. Available 24 hours a day, 7 days a week.
Pharmacy **As of January 1, 2022, Medi-Cal Rx will be responsible to review and authorize Medications.** Medi-Cal Rx Website: www.Medi-CalRx.dhcs.ca.gov MRx Pharmacy Locator: https://medi-calrx.dhcs.ca.gov/home/find-a-pharmacy	Outpatient Prescription Medications have been carved out to the State and are no longer managed by the Health Plans.	**How to access the Rx Portal and obtain access:** For Provider Portal registration assistance and training: https://medi-calrx.dhcs.ca.gov/home/education/ Email: MediCalRxEducationOutreach@magellanhealth.com	Medi-Cal Rx Customer Service Center Line 1-800-977-2273, 24 hours a day, 7 days a week 711 for TTY, Monday to Friday 8 a.m.–5 p.m.

LA County

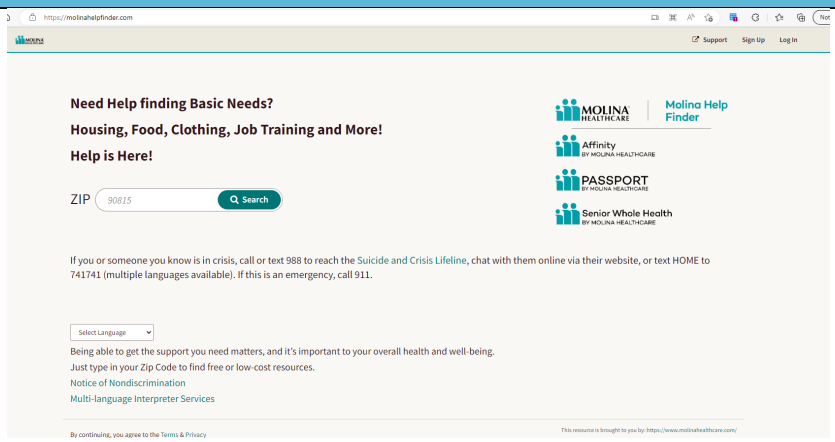
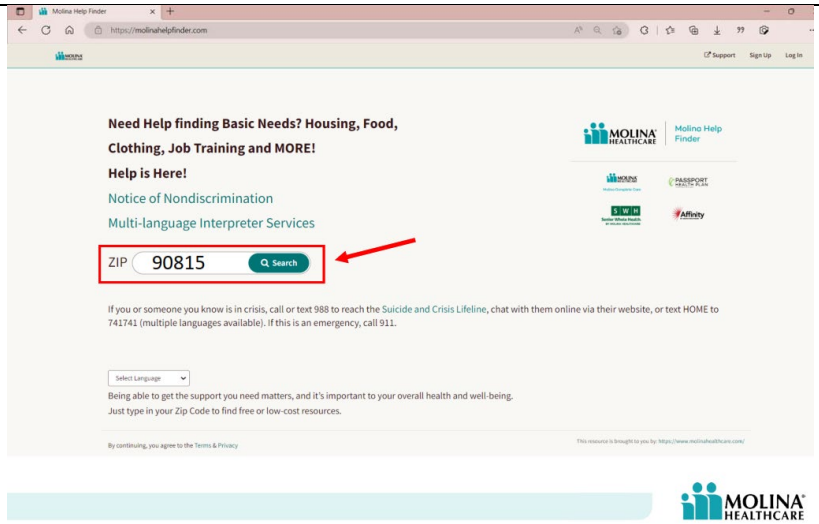
Department	Telephone Number	Email/Web Link	Hours of Operation
Meds: https://medi-calrx.dhcs.ca.gov/home/cdl			
Denti-Cal (for dental services)	1-800-322-6384	https://www.denti-cal.ca.gov/find-a-dentist/home	Available Monday-Friday 8 a.m.–5 p.m.
March Vision (for vision services)	888-493-4070 (844) 336-2724	https://marchvisioncare.com	
Adult Protective Services	**24-Hour Abuse Hotline:** (877) 477-3646 **General Information, toll-free in LA & Vicinity:** (888) 202-4248 **APS Mandated Reporter Hotline:** (877) 477-3646 or (877) 4-R-Seniors, M-F, 8:30 a.m.-5 p.m.	http://www.cdss.ca.gov/inforesources/County-APS-Offices	24 hours
Child Protective Services	(800) 540-4000	https://www.cdss.ca.gov/Reporting/Report-Abuse/Child-Protective-Services Online Reporting: https://reportChildAbuseLA.org	24 hours

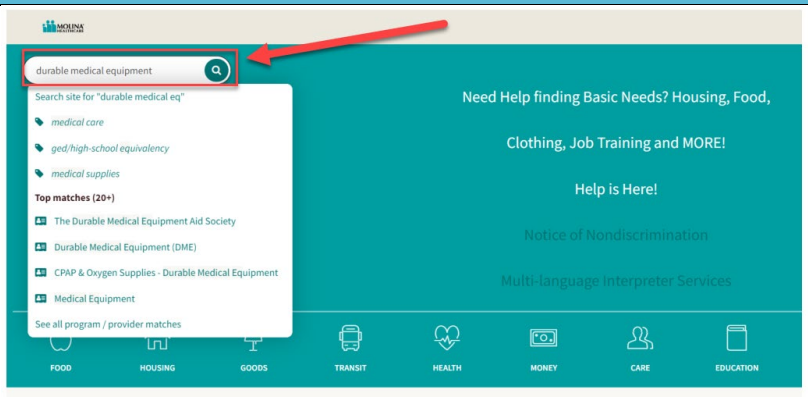
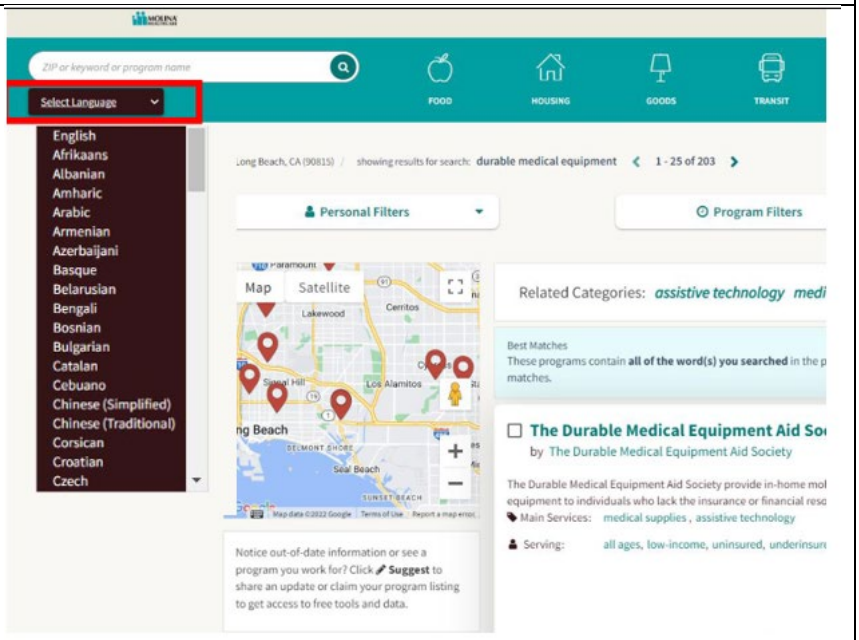
LA County

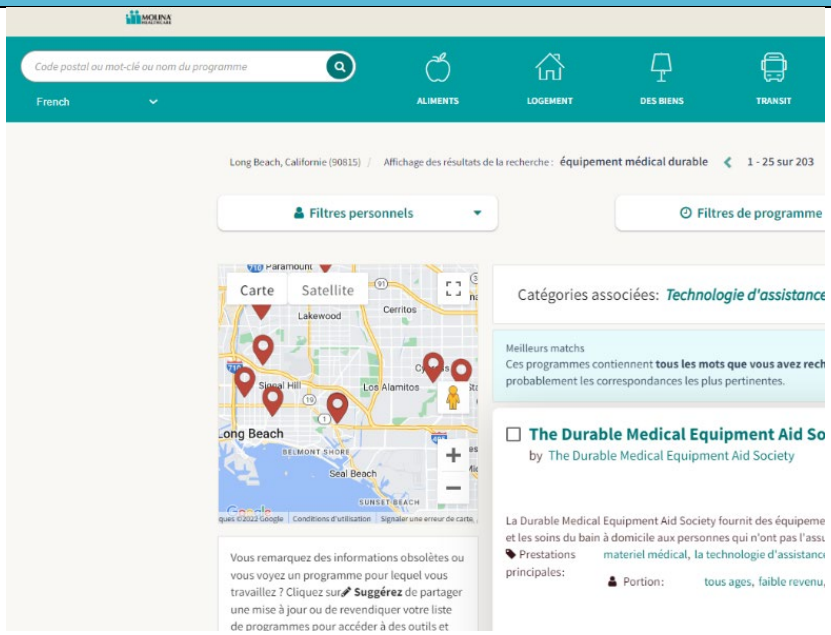
Group (can call on the status of a Prior Authorization Request)	Telephone Number	Email/Web Link	Hours of Operation
HEALTHCARE LA IPA (MEDPOINT MANAGEMENT MSO)	(818) 702-0100	http://www.medpointmanagement.com	
VALLEY PRESBYTERIAN-PREFERRED IPA OF CALIFORNIA	Phone: (818) 844-8028 Fax: (818) 265-0801	http://preferredipa.com	Monday through Friday 8:30 a.m.–5 p.m.
EL PROYECTO DEL BARRIO INC	(818) 702-0100	http://www.medpointmanagement.com	
GLOBAL CARE MEDICAL GROUP IPA	(818) 702-0100	http://www.medpointmanagement.com	
ALLIED PACIFIC OF CALIFORNIA IPA	(877) 282-8272 (626) 282-0288	http://www.nmm.cc/nmm/en/index.jsp	Monday through Friday 9 a.m.–5 p.m.
ALTAMED IPA	(855) 848-5252 (866) 880-7805	https://www.altamed.org	
ANGELES IPA	(714) 947-8600 Fax: (714) 947-8702	http://www.angelesipa.com	
SOUTH ATLANTIC	(323)725-0167	http://meditab.in:8080/samg/site/index.html	
CAL CARE IPA INC	951-280-7700 855-257-9964 (toll-free) 951-280-8200 (fax)	https://www.calcareipa.com	

Molina Help Finder

The Molina Help Finder is a one-stop social services platform, free (available 24/7), powered by Findhelp (formerly Aunt Bertha) – that assists Molina members in finding the resources and services they need when they need them right in their communities. It's an online community resource directory for community-based organizations and government resources available to all Molina Providers and Members. ECM Providers can search thousands of programs, community-based resources, and services in every zip code in the United States. The Molina Help Finder is a resource for all counties. The Molina Help Finder's database spans all domains of need, including food pantries, childcare, education, housing, employment, financial assistance, legal representation, and more.

INSTRUCTIONS	SCREENSHOT
Step 1: Access the Molina Help Finder by clicking the link: https://molinahelpfinder.com/	
Step 2: Enter the zip code under **ZIP**	

INSTRUCTIONS	SCREENSHOT
Step 3: Conduct a **Search**	
Step 4: You can also select a different **language**	

INSTRUCTIONS	SCREENSHOT
Step 5: Content will change to **the selected language**	

Molina's Just the Fax

Molina communicated the following Just the Fax to their entire network of providers to educate them on CalAim's Enhanced Care Management Program for eligible Medi-Cal beneficiaries with complex medical and social needs. We also wanted to inform our network that our ECM Providers are an extension of Molina. We understand that ECM Providers might experience challenges when contacting providers to request member information, such as treatment plans and medication information, to support care coordination needs and comply with our ECM requirements. ECM Providers can reference this communication when dealing with providers unaware of our ECM Program.

MOLINA HEALTHCARE

www.molinahealthcare.com

JUST THE FAX

December 29, 2022 | **Page** 1 **of** 3

THIS CA UPDATE HAS BEEN SENT TO THE FOLLOWING:

COUNTIES:

- ☒ Imperial
- ☒ Riverside/San Bernardino
- ☒ Los Angeles
- ☐ Orange
- ☒ Sacramento
- ☒ San Diego

LINES OF BUSINESS:

- ☒ Molina Medi-Cal Managed Care
- ☐ Molina Medicare Options Plus
- ☐ Molina Dual Options Cal MediConnect Plan (Medicare-Medicaid Plan)
- ☐ Molina Marketplace (Covered CA)

PROVIDER TYPES:

- ☒ **Medical Group/ IPA/MSO**

Primary Care

- ☒ IPA/MSO
- ☒ Directs

Specialists

- ☒ Directs
- ☒ IPA
- ☒ **Hospitals**

Ancillary

- ☐ CBAS
- ☒ SNF/LTC
- ☐ DME
- ☐ Home Health
- ☐ Other

Enhanced Care Management Benefit for Medi-Cal Beneficiaries with Complex Medical & Social Needs

This is an advisory notification to Molina Healthcare of California (MHC) network providers. Per the Department of Health Care Services (DHCS) guidance, beginning January 1, 2023, Molina Healthcare of California will add two additional populations of focus to the Enhanced Care Management (ECM) benefit; Adults Living in the Community and At Risk for LTC Institutionalization and Adult Nursing Facility Residents Transitioning to the Community.

WHAT IS ECM?

Enhanced Care Management (ECM) is a statewide benefit to serve eligible Medi-Cal beneficiaries with complex medical and social needs through systematic coordination of services and comprehensive intensive care management that is community based, interdisciplinary, high touch, and person-centered.

The ECM benefit built on the previous Health Homes Program (HHP) and Whole Person Care (WPC) Pilots. ECM, along with Community Supports (CS), has replaced both initiatives, scaling up the interventions to form a statewide care management approach. ECM offers comprehensive, whole person care management to high-need, high-cost Medi-Cal Managed Care Members, with the overarching goals of improving care coordination, integrating services, facilitating community resources, addressing SDOH, improving health outcomes and decreasing inappropriate utilization and duplication of services.

ECM includes the provision of the following core services:

- Outreach and Engagement
- Comprehensive Assessment & Care Plan
- Health Promotion
- Comprehensive Transitional Care
- Enhanced Coordination of Care
- Individual and Family/Social Supports
- Coordination of & Referral to Community & Social Services

POPULATIONS OF FOCUS

DHCS has identified specific target populations with qualifying criteria for the ECM benefit. Members who are newly accessing the benefit must meet the qualifying criteria for these Populations of Focus to receive the ECM benefit.

The following ECM Populations of Focus were implemented 1/1/2022:

- **Individuals and Families Experiencing** Homelessness (Riverside, San Bernardino, Sacramento, San Diego, Imperial and Los Angeles)
- **High Utilizer Adults** (Riverside, San Bernardino, Sacramento, San Diego, Imperial and Los Angeles)
- **Adults with SMI/SUD** (Riverside, San Bernardino, Sacramento, San Diego, Imperial and Los Angeles)

If you are not contracted with Molina and wish to opt out of the Just the Fax, email: mhcproviderjustthefax@molinahealthcare.com
Please include provider name and fax number and you will be removed within 30 days.

- **Individuals transitioning from Incarceration** (Los Angeles and Riverside ONLY, accepting external referrals for Sacramento and San Diego)
- **Adults with Intellectual or Developmental Disabilities** (I/DD) (Riverside, San Bernardino, Sacramento, San Diego, Imperial and Los Angeles) AND met criteria for another population of focus
- **Adult Pregnant and Postpartum at risk for Adverse Perinatal Outcomes** (Riverside, San Bernardino, Sacramento, San Diego, Imperial and Los Angeles) AND met criteria for another population of focus

The following ECM Populations of Focus will be implemented 1/1/2023:

- **Adults Living in the Community and At Risk for LTC Institutionalization** (Riverside, San Bernardino, Sacramento, San Diego, Imperial and Los Angeles)
- **Adult Nursing Facility Residents Transitioning to the Community** (Riverside, San Bernardino, Sacramento, San Diego, Imperial and Los Angeles)

MEMBER IDENTIFICATION AND REFERRAL

Molina identifies members who meet the DHCS criteria for the POFs specified and an assigned ECM provider will conduct outreach to the member. Members must opt-in to receive the benefit and through this process, they consent to information sharing for the provision of ECM services.

Members may also be referred to ECM using the Molina ECM Referral form, which is available on the Molina provider website. We also accept any other referral forms used county-wide or by other health plans.

ECM PROVIDERS AND CARE COORDINATION

Members are assigned to an ECM provider and Lead Care Manager, who is responsible for coordinating all aspects of the members medical, behavioral health and social needs. The intensive care coordination services provided by the ECM provider are designed to offer an extra layer of support for members with complex medical and social needs.

Molina has contracted with ECM providers that have a wide variety of expertise, including but not limited to, medical groups, community-based organizations, homeless services agencies, and county behavioral health departments.

ECM providers will encourage members to visit their doctors, be compliant with their treatment plans and help arrange transportation or accompany members to the doctor at a member's request.

Molina's contracted ECM providers are an extension of Molina Healthcare of California – they are your partners in assisting our members with their needs. For members enrolled in ECM, you may be contacted by an ECM provider to coordinate care for the member, and they may request information, such as treatment plans, medication information, etc. to support care coordination needs and comply with ECM requirements. ECM providers may also share information with you regarding the member, especially with regards to authorizations or medications.

We are excited to expand the ECM benefit to additional populations of focus and appreciate your partnership and support in providing quality care for our members.

For additional detail on the ECM benefit, please reference the DHCS ECM Policy Guide on the DHCS CalAIM website: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide-Updated-May-2022-v2.pdf

If you are not contracted with Molina and wish to opt out of the Just the Fax, email: mhcproviderjustthefax@molinahealthcare.com
Please include provider name and fax number and you will be removed within 30 days.

QUESTIONS

If you have any questions regarding the notification, please contact your Molina Provider Services Representative. Please refer to the phone numbers listed below:

Service County Area	Provider Services Representative	Contact Number	Email Address
San Diego / Imperial County	Carlos Liciaga	858-614-1591	Carlos.Liciaga@molinahealthcare.com
Los Angeles	Clemente Arias	562-517-1014	Clemente.Arias@molinahealthcare.com
California Hospital Systems	Deletha Foster	909-577-4351	Deletha.Foster@molinahealthcare.com
Sacramento	Jennifer Rivera Carrasco	562-542-2250	Jennifer.RiveraCarrasco@molinahealthcare.com
San Bernardino	Luana McIver	909-501-3314	Luana.McIver@molinahealthcare.com
California Hospital Systems	Shelly Lilly	858-614-1586	Michelle.Lilly@molinahealthcare.com
San Bernardino / Riverside County	Vanessa Lomeli	909-577-4355	Vanessa.Lomeli2@molinahealthcare.com
San Diego / Imperial County	Salvador Perez	562-549-3825	Salvador.Perez@molinahealthcare.com
Los Angeles / Orange County	Maria Guimoye	562-549-4390	Maria.Guimoye@molinahealthcare.com
San Diego/ Imperial County	Briana Givens	562-549-4403	Briana.Givens@molinahealthcare.com

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mhcproviderjustthefax@molinahealthcare.com
Please include provider name and fax number and you will be removed within 30 days.

Member Handbook

The 2023 Member Handbook (also known as the Evidence of Coverage, EOC) is located on Molina's public website (see link below):

https://www.molinahealthcare.com/members/ca/en-us/-/media/Molina/PublicWebsite/PDF/members/ca/en-us/Medi-Cal/2023-English-Spanish-EOC.pdf

We urge our ECM Providers to review the latest Member Handbook for more information on member benefits and additional resources.

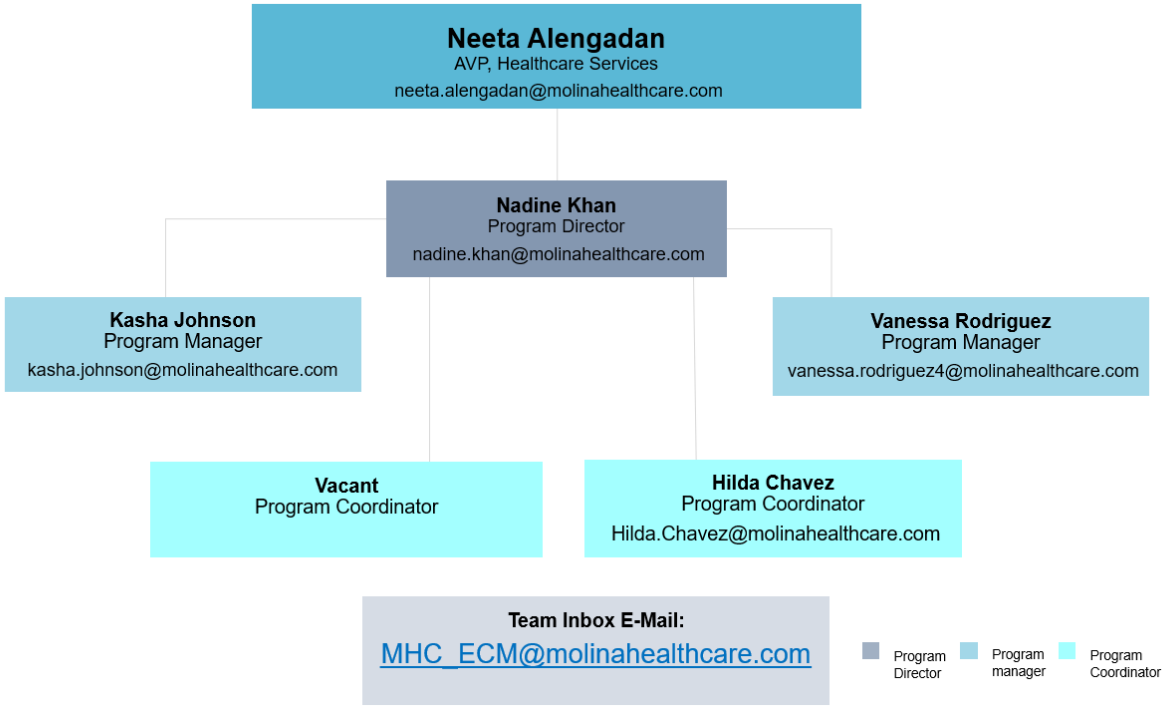
Molina's Medi-Cal Provider Manual

Molina's Medi-Cal Provider Manual is an extension of our ECM Providers contract. The Medi-Cal Provider Manual contains policies, procedures, and regulatory/contractual requirements to support you in providing comprehensive care to our members and understanding our programs and processes. The latest Molina Medi-Cal Provider Manual is located on Molina's public website (see link below):

https://www.molinahealthcare.com/providers/ca/medicaid/manual/medical.aspx

Molina's ECM Team

For questions regarding Molina's ECM Program, please contact Molina's ECM Team Inbox: MHC_ECM@molinahealthcare.org. If you don't receive a response within 24-48 hours, please escalate to Molina's ECM Team (listed below):



Attachments

Review the attachments below:

CA HRA Templates in all languages

ECM Letter Templates

IHSS Referral form- San Bernardino

IHSS Referral form SOC295

건강 설문 조사

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회원 이름:	**회원의 자택 전화번호:**
	회원의 휴대전화 번호:
본 설문조사를 작성한 사람:	**회원의 의료보험 ID:**
설문조사 작성자의 전화번호:	**회원의 생년월일:** / /
회원과의 관계:	**오늘 날짜:** / /

	문항	답변
1.	영어 이외에 다른 언어가 필요하십니까?	☐ 아랍어 ☐ 크리올어 ☐ 불어 ☐ 중국어 ☐ 러시아어 ☐ 소말리아어 ☐ 스페인어 ☐ 베트남어 ☐ 없음 ☐ 다른 언어
2.	다른 언어일 경우, 기재해 주십시오.	
3.	우리가 알고 있어야 하는 특별한 선호사항이 있습니까?	해당 사항에 모두 체크: ☐ 문화적 선호 문화적 선호에 대해 상세히 설명해 주십시오. _____ ☐ 청각장애 청각장애에 대해 자세히 설명해 주십시오: _____ ☐ 리터러시 리터러시 선호에 대해 자세히 설명해 주십시오.

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		_____ ☐ 종교적/영적 요구 또는 선호 종교적/영적 요구 또는 선호: _____ ☐ 시각장애 시각장애에 대해 자세히 설명해 주십시오. _____ ☐ 기타 특별 선호사항 특별 선호사항에 대해 자세히 설명해 주십시오. _____ ☐ 없음
4.	현재 귀하의 **주된** 건강 관심사는 무엇입니까?	
5.	임신 상태입니까?	☐ 예 ☐ 아니요 ☐ 해당 없음
6.	천식, 만성 폐쇄성 폐질환 또는 낭포성 섬유증과 같은 폐의 문제가 있습니까?	☐ 천식 ☐ 만성 폐쇄성 폐질환(COPD) ☐ 낭포성 섬유증 ☐ 없음
7.	심방세동, 관상동맥질환, 말초동맥질환, 울혈성 심부전이나 뇌졸중과 같은 심장 또는 순환 문제가 있습니까?	☐ 심방세동 ☐ 관상동맥질환/말초동맥

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		질환 ☐ 울혈성 심부전 ☐ 대뇌혈관사고/뇌졸중 ☐ 고혈압 ☐ 없음
8.	만성신부전 또는 투석이 필요한 말기신질환과 같은 신장 문제가 있습니까?	☐ 만성신부전 ☐ 투석이 필요한 말기신질환 ☐ 없음
9.	의사가 귀하에게 우울증, 조현병 또는 양극성 장애와 같은 행동 건강 상태 진단을 내렸습니까?	☐ 우울증 ☐ 조현병 ☐ 양극성 ☐ 없음
10.	발작, 기억력(치매) 또는 뇌졸중과 같이 뇌에 영향을 주는 상태가 있습니까?	☐ 발작 ☐ 대뇌혈관사고/뇌졸중 ☐ 치매 ☐ 알츠하이머 ☐ 기타 뇌 상태: _____ ☐ 없음
11.	간경변증이 있습니까?	☐ 예 ☐ 아니요
12.	겸상적혈구가 있습니까?	☐ 예 ☐ 아니요
13.	HIV 또는 AIDS가 있습니까?	☐ HIV ☐ AIDS ☐ 없음

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14.	항암화학요법, 방사선치료 또는 수술로 치료 중인 활성 암이 있습니까?	☐ 예 ☐ 아니요
15.	당뇨병(당류)이 있습니까?	☐ 예 ☐ 아니요
16.	류마티스성 관절염이 있습니까?	☐ 예 ☐ 아니요
17.	기타 상태	☐ 기타 _____ _____ ☐ 없음
18.	과거 6개월간 응급실을 방문한 적이 있습니까?	☐ 예 ☐ 아니요
	a) 있을 경우, 응급실 방문 횟수는 몇 번입니까?	
	b) 응급실 방문 이유:	
19.	과거 6개월간 병원에 입원한 적이 있습니까?	☐ 예 ☐ 아니요
	a) 있을 경우, 입원 기간을 몇일입니까?	
	b) 있을 경우, 입원 이유:	

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20.	약의 용도와 투약 이유를 이해하고 있습니까?	☐ 예 ☐ 아니요 ☐ 처방 약 없음 ✓ 없을 경우, 권장 사항: • 약물을 "갈색 봉투"에 담아 다음 의사 진료 시 가져가십시오. 또는 • 저희 약사에게 문의하십시오. (855) 658-0918, TTY: 711, 월요일 – 금요일, 오전 8 시 – 오후 5 시. 귀하의 약물을 검토하여 궁금한 사항에 답변해줄 것입니다.
21.	약물 투약에 도움이 필요하십니까?	☐ 예 ☐ 아니요
22.	건강검진 서류 작성 시 도움이 필요하십니까?	☐ 예 ☐ 아니요
23.	의사 진료 중 질문 답변에 도움이 필요하십니까?	☐ 예 ☐ 아니요
24.	귀하와 비슷한 연령의 다른 사람에 비해 귀하의 건강 상태는:	☐ 훌륭함 ☐ 매우 양호함 ☐ 양호함 ☐ 괜찮음 ☐ 좋지 않음
25.	사고, 기억, 또는 의사 결정에 변화가 있었습니까?	☐ 예 ☐ 아니요
26.	올해 독감 예방 주사를 맞았습니까?	☐ 예 ☐ 아니요
27.	현재 거주 상황은 무엇입니까?	☐ 노숙인

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		☐ 홀로 거주 ☐ 그룹홈에 거주 ☐ 요양 기관에 거주 ☐ 쉼터에 거주 ☐ 원호 생활 시설에 거주 ☐ 다른 가족과 거주 ☐ 친족관계가 아닌 타인과 거주 ☐ 배우자와 거주 ☐ 집 밖 거주 ☐ 주 이외 의료 시설에 거주 ☐ 위 해당 사항 없음 ☐ 기타
	a) 기타일 경우, 설명해 주십시오.	
28.	집안에서 안전하게 거주하며 쉽게 이동할 수 있습니까?	☐ 예 ☐ 아니요
29.	아닐 경우, 거주하는 장소에 다음 사항이 있습니까?	
	a) 양호한 조명	☐ 예 ☐ 아니요
	b) 양호한 난방	☐ 예 ☐ 아니요
	c) 양호한 냉방	☐ 예 ☐ 아니요
	d) 계단용 난간이나 경사로	☐ 예 ☐ 아니요 ☐ 해당 없음 - 계단이나 경사로 없음.

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	e) 온수	☐ 예 ☐ 아니요
	f) 실내 화장실	☐ 예 ☐ 아니요
	g) 잠금장치 밖으로 나갈 수 있는 문	☐ 예 ☐ 아니요
	h) 집이나 집 안의 계단으로 들어갈 수 있는 계단	☐ 예 ☐ 아니요
	i) 엘리베이터	☐ 예 ☐ 아니요
	j) 휠체어를 사용할 수 있는 공간	☐ 예 ☐ 아니요 ☐ 해당 없음 - 휠체어가 필요하지 않습니다.
	k) 집 밖으로 나갈 수 있는 분명한 길	☐ 예 ☐ 아니요
30.	지난 달에 넘어진 적이 있습니까?	☐ 예 ☐ 아니요
31.	넘어질까봐 염려되십니까?	☐ 예 ☐ 아니요
32.	아래 제시된 행동에 도움이 필요하십니까?	
	a) 목욕 또는 샤워	☐ 예 ☐ 아니요
	b) 계단 오르기	☐ 예 ☐ 아니요
	c) 먹기	☐ 예 ☐ 아니요
	d) 옷 입기	☐ 예 ☐ 아니요
	e) 이 닦기, 머리 빗기, 면도	☐ 예 ☐ 아니요
	f) 식사 만들기 또는 요리	☐ 예 ☐ 아니요

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	g) 침대나 의자에서 일어나기	☐ 예 ☐ 아니요
	h) 식품 구매 또는 섭취	☐ 예 ☐ 아니요
	i) 화장실 사용	☐ 예 ☐ 아니요
	j) 걷기	☐ 예 ☐ 아니요
	k) 설겆이 또는 세탁	☐ 예 ☐ 아니요
	l) 수표 작성 또는 돈 관리	☐ 예 ☐ 아니요
	m) 진료를 보거나 친구를 만나기 위한 이동	☐ 예 ☐ 아니요
	n) 집안일 또는 정원일	☐ 예 ☐ 아니요
	o) 친지나 가족 방문	☐ 예 ☐ 아니요
	p) 전화 사용	☐ 예 ☐ 아니요
	q) 약속 관리	☐ 예 ☐ 아니요
33.	위 항목 중 해당되는 사항이 있을 경우, 이러한 행동에 필요한 모든 도움을 받고 있습니까?	☐ 예 ☐ 아니요
34.	필요할 때 도와주려 하거나 도와줄 수 있는 가족이나 타인이 있습니까?	☐ 예 ☐ 아니요
35.	귀하를 돌보는 사람이 필요한 모든 도움을 제공하는 데 어려움을 겪고 있다고 생각하십니까?	☐ 예 ☐ 아니요 ☐ 돌보는 사람이 없습니다.

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36.	음식, 집세, 청구서 및 약값을 지불할 돈이 떨어질 때가 있습니까?	☐ 예 ☐ 아니요
37.	누군가 귀하의 허락 없이 귀하의 돈을 사용하고 있습니까?	☐ 예 ☐ 아니요
38.	사전의료지시는 귀하가 스스로 무언가를 할 수 없을 정도로 상태가 악화될 경우 사랑하는 이가 귀하의 의료적 선택에 관해 알 수 있도록 하는 양식입니다. 사망 선택 유언이나 사전의료지시가 마련되어 있습니까?	☐ 예 ☐ 아니요
	a) 있을 경우, 어떤 종류의 문서입니까?	
	b) 있을 경우, PCP/의사에게 사본이 있습니까?	☐ 예 ☐ 아니요
	c) 없을 경우, 보다 자세한 정보를 드릴까요?	☐ 예 ☐ 아니요
39.	(39~44번 문항의 경우, 13세 이상의 응답자만 답변하십시오) 지난 3 개월간, 음주 또는 약물 사용을 줄이거나 중단해야 한다고 느낀 적이 있습니까?	☐ 예 ☐ 아니요
40.	지난 3개월간, 귀하에게 음주 또는 약물 사용을 줄이거나 중단해야 한다고 말함으로써 귀하를 불편하게 한 사람이 있었습니까?	☐ 예 ☐ 아니요

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41.	지난 3개월간, 음주 또는 약물 사용의 양에 대해 죄책감을 느끼거나 좋지 않은 기분인 적이 있습니까?	☐ 예 ☐ 아니요
42.	지난 3개월간, 음주를 하거나 약물을 사용하고 싶어서 일어난 적이 있습니까?	☐ 예 ☐ 아니요
43.	약물이나 음주에 관해 귀하에게 문제가 있다고 생각하십니까?	☐ 예 ☐ 아니요
44.	39 ~ 43번 문항에 예라고 답한 경우, 사례 담당자가 귀하에게 전화하여 지원/교육을 제공하길 바라십니까?	☐ 예 ☐ 아니요
45.	지난 2주간, 무언가를 하는 데 관심이나 즐거움이 거의 없었던 적이 얼마나 자주 있습니까?	☐ 전혀 없음 ☐ 며칠 ☐ 절반(7 일) 이상 ☐ 거의 매일
46.	지난 2주간, 기분이 가라앉거나, 우울하거나 절망적인 감정을 가졌던 적이 얼마나 자주 있습니까?	☐ 전혀 없음 ☐ 며칠 ☐ 절반(7 일) 이상 ☐ 거의 매일
47.	지난 1개월(30일)간, 외롭다고 느낀 적이 몇일이나 있습니까?	☐ 없음 - 외로움을 느끼지 않음 ☐ 5일 미만 ☐ 절반(15일) 이상 ☐ 대부분 - 늘 외로움을 느낌
48.	누군가에 대해 두려움을 느끼거나 누군가가 귀하에게 상처를 줍니까?	☐ 예 ☐ 아니요

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	시간을 내어 설문조사에 응해주셔서 감사합니다. 누군가가 귀하에게 연락을 취할 수도 있습니다. 귀하의 건강 관리에 추가적인 도움을 필요로 하실 경우, "ICT"라 부르는 "부서간 관리 팀(Interdisciplary Care Team)"에서 귀하의 필요사항을 논의할 수 있습니다. 귀하의 주치의, 귀하의 사례 담당자, 귀하의 간병인, 귀하 자신 등 귀하의 관리 팀 구성원을 포함할 수 있습니다. 이 팀은 직접, 또는 전화상으로 만나 귀하의 건강 관리 필요사항에 부합하는 계획을 마련하기 위해 협력할 수 있습니다. **위 사항을 읽고 이해했다는 서명을 해주십시오.** _____

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健康調查

會員姓名：	**會員的住宅電話：** **會員的手提電話：**
完成此調查問卷的人士：	**會員的健康照護 ID：**
完成調查問卷人士的電話：	**會員的出生日期：** / /
與會員的關係：	**今日日期:** / /

	問題	回答
1.	您是否有英文以外的其他語言需要？	☐ 阿拉伯語 ☐ 克里奧語 ☐ 法語 ☐ 普通話 ☐ 俄語 ☐ 索馬里語 ☐ 西班牙語 ☐ 越南語 ☐ 無 ☐ 其他語言
2.	如有其他語言需要，請說明：	
3.	**您**有什麼我們應知道的特殊偏好**嗎**？	請勾選所有適用選項： ☐ 文化偏好 闡述任何文化偏好： _____ ☐ 聽力障礙 闡述任何聽力障礙 偏好： _____ ☐ 讀寫能力 闡述任何讀寫能力偏好： _____ ☐ 宗教／精神需求或偏好

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		闡述任何宗教／精神需求或 偏好： _____ ☐ 視覺障礙 闡述任何視覺障礙 偏好： _____ ☐ 其他特殊偏好 闡述任何特殊偏好： _____ ☐ 無
4.	您現在 **主要** 的健康問題是什麼？	
5.	您是否懷孕了？	☐ 是 ☐ 否 ☐ 不適用
6.	**您的肺部有什麼問題嗎，如哮喘、慢性阻塞性肺病或囊性纖維化**？	☐ 哮喘 ☐ 慢性阻塞性肺病 (COPD) ☐ 囊性纖維化 ☐ 無
7.	**您的心臟或循環系統有什麼問題嗎，如心房纖顫、冠狀動脈疾病、外周動脈疾病、充血性心力**衰竭或中風？	☐ 心房纖顫 ☐ 冠狀動脈疾病／外周動脈 疾病 ☐ 充血性心力衰竭 ☐ 腦血管意外／中風 ☐ 高血壓

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		☐ 無
8.	**您的腎臟有什麼問題嗎，如慢性腎病或終末期腎病透析？**	☐ 慢性腎病 ☐ 終末期腎病透析 ☐ 無
9.	醫生是否曾診斷出**您的行為健康狀況出現問題，如抑鬱症、精神分裂症或雙相情感障礙？**	☐ 抑鬱症 ☐ 精神分裂症 ☐ 雙相情感障礙 ☐ 無
10.	**您是否有什麼狀況影響您的大腦，如癲癇、記憶問題（癡呆）或中風？**	☐ 癲癇 ☐ 腦血管意外／中風 ☐ 癡呆 ☐ 阿滋海默氏症 ☐ 其他腦部狀況： _____ ☐ 無
11.	您是否患有肝硬化？	☐ 是 ☐ 否
12.	您是否患有鐮狀細胞疾病？	☐ 是 ☐ 否
13.	您是否感染了人類免疫力缺乏病毒 (HIV) 或患有後天免疫力缺乏症 (AIDS)？	☐ HIV ☐ AIDS ☐ 兩者皆否
14.	您是否患有正在接受化療、放療或手術治療的活性癌症？	☐ 是 ☐ 否
15.	您是否患有糖尿病？	☐ 是 ☐ 否
16.	您是否患有類風溼性關節炎？	☐ 是 ☐ 否

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17.	其他狀況	☐ 其他 _____ _____ ☐ 無
18.	在過去的 6 個月裡，您是否曾到過急症室就診？	☐ 是 ☐ 否
	a) 倘答案為「是」，曾到過急症室就診多少次？	
	b) 到急症室就診的理由：	
19.	在過去的 6 個月裡，您是否曾住院過夜？	☐ 是 ☐ 否
	a) 倘答案為「是」，住院次數為多少？	
	b) 倘答案為「是」，住院理由：	

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20.	您是否知道您的藥物作用及您服用這些藥物的理由？	☐ 是 ☐ 否 ☐ 沒有處方藥物 ✓ 倘答案為「否」，我們建議： • 將藥物放在一個「棕色袋子」裡，然後帶到您下次預約看診的醫生處諮詢。 或 • 致電我們的藥劑師，電話：(855) 658-0918，聽障專線：711，週一至週五上午 8 時 至下午 5 時，藥劑師將和您一起檢查您的藥物並回答任何問題。
21.	您在服用藥物時是否需要幫助？	☐ 是 ☐ 否
22.	您在填寫健康表格時是否需要幫助？	☐ 是 ☐ 否
23.	您在看診期間回答醫生問題時是否需要幫助？	☐ 是 ☐ 否
24.	與同齡人相比，您認為自己的健康狀況為：	☐ 極好 ☐ 很好 ☐ 良好 ☐ 普通 ☐ 糟糕
25.	您在思考、記憶或做決定方面是否有任何改變？	☐ 是 ☐ 否
26.	您今年是否接種過流感疫苗？	☐ 是 ☐ 否
27.	您目前的生活狀況如何？	☐ 無家可歸 ☐ 獨居

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		☐ 住在團體家屋 ☐ 住在護理機構 ☐ 住在收容所 ☐ 住在輔助生活機構 ☐ 與其他家庭成員共住 ☐ 與其他不相關人士共住 ☐ 與配偶共住 ☐ 住在家外安置機構 ☐ 住在州外醫療機構 ☐ 以上皆非 ☐ 其他
	a) 倘答案為「其他」，請說明：	
28.	您是否能在家中安全生活及輕鬆地四處走動？	☐ 是 ☐ 否
29.	倘答案為「否」，您所居住的地方是否配備：	
	a) 良好的照明	☐ 是 ☐ 否
	b) 良好的供暖	☐ 是 ☐ 否
	c) 良好的製冷	☐ 是 ☐ 否
	d) 樓梯或坡道的欄杆	☐ 是 ☐ 否 ☐ 不適用 – 沒有樓梯或坡道。
	e) 熱水	☐ 是 ☐ 否

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	f) 室內洗手間	☐ 是 ☐ 否
	g) 通往室外可上鎖的門	☐ 是 ☐ 否
	h) 通往家中的樓梯或屋內的樓梯	☐ 是 ☐ 否
	i) 升降機	☐ 是 ☐ 否
	j) 使用輪椅的空間	☐ 是 ☐ 否 ☐ 不適用 – 我不需要輪椅。
	k) 離開住宅的暢通通道	☐ 是 ☐ 否
30.	您上個月是否有跌倒？	☐ 是 ☐ 否
31.	您是否害怕跌倒？	☐ 是 ☐ 否
32.	對於以下所示的任何行動，您是否需要幫助？	
	a) 沐浴或淋浴	☐ 是 ☐ 否
	b) 上樓梯	☐ 是 ☐ 否
	c) 進食	☐ 是 ☐ 否
	d) 穿著	☐ 是 ☐ 否
	e) 刷牙、梳頭髮、剃鬚	☐ 是 ☐ 否
	f) 煮飯或烹飪	☐ 是 ☐ 否
	g) 從床上或椅子上起來	☐ 是 ☐ 否
	h) 購物和獲取食物	☐ 是 ☐ 否

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	i) 使用洗手間	☐ 是 ☐ 否
	j) 行走	☐ 是 ☐ 否
	k) 洗碗或洗衣服	☐ 是 ☐ 否
	l) 開支票或記錄金錢	☐ 是 ☐ 否
	m) 乘車去看醫生或探望朋友	☐ 是 ☐ 否
	n) 做家務或在庭院勞動	☐ 是 ☐ 否
	o) 外出探望家人或朋友	☐ 是 ☐ 否
	p) 使用電話	☐ 是 ☐ 否
	q) 記錄預約	☐ 是 ☐ 否
33.	倘以上任何一項行動所對應的答案為「是」，那麼您在這些行動中是否得到了所需的所有幫助？	☐ 是 ☐ 否
34.	您的家人或其他人是否願意或能否在您需要時幫助您？	☐ 是 ☐ 否
35.	您是否覺得照顧者很難給您所有您需要的幫助？	☐ 是 ☐ 否 ☐ 我沒有照顧者照顧我。
36.	您是否有時沒有錢支付食物、房租、帳單及藥物？	☐ 是 ☐ 否
37.	是否有人在沒有得到**您同意的情況下用您的錢**？	☐ 是 ☐ 否

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38.	預設指示是一份表格，可讓您的親友知道您在病重時無法自行做出的健康照護選擇。 您是否已立生前遺囑或做出預設指示？	☐ 是 ☐ 否
	a) 倘答案為「是」，那麼是什麼類型的文件？	
	b) 倘答案為「是」，您的 PCP／醫生是否擁有一份複本？	☐ 是 ☐ 否
	c) 倘答案為「否」，我能否向您傳送更多資訊？	☐ 是 ☐ 否
39.	（問題 39 至 44 僅適合年滿 13 歲的人士回答） 在過去的三個月裡，您是否曾覺得應該減少或停止飲酒或吸毒？	☐ 是 ☐ 否
40.	在過去的三個月裡，是否曾有人告訴您要減少或停止飲酒或吸毒而令您心煩意亂？	☐ 是 ☐ 否
41.	在過去的三個月裡，您是否曾對自己飲酒或吸毒的程度感到內疚或難過？	☐ 是 ☐ 否
42.	在過去的三個月裡，您是否曾一覺醒來就想飲酒或吸毒？	☐ 是 ☐ 否
43.	您是否覺得自己有吸毒或飲酒方面的問題？	☐ 是 ☐ 否
44.	倘問題 39-43 的答案為「是」，您是否希望案例經理致電您提供支援／教育？	☐ 是 ☐ 否

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45.	在過去的兩週裡，您有多經常對做任何事情都沒有什麼興趣或樂趣？	☐ 完全沒有過 ☐ 數天 ☐ 超過一半的時間 ☐ 幾乎每天
46.	在過去的兩週裡，您有多經常感到難過、沮喪或絕望？	☐ 完全沒有過 ☐ 數天 ☐ 超過一半的時間 ☐ 幾乎每天
47.	在過去的一個月（30 天）裡，您有多少天感到孤獨？	☐ 無 – 我從不感到孤獨 ☐ 少於 5 天 ☐ 超過一半的時間（超過 15 天） ☐ 大多數日子 – 我總是感到孤獨
48.	您是否害怕有人傷害您或是否有人正在傷害您？	☐ 是 ☐ 否
	感謝您花時間完成此份調查問卷。 有人可能會聯絡您。 倘若您需要些許額外幫助來照顧您的健康，我們可以在一個「跨學科護理團隊」（亦稱為「ICT」）會議上討論您的需求。 我們會邀請您的護理團隊成員，例如初級護理醫生、案例經理、照顧者及您自己，參加這個會議。 這個團隊可以面對面或透過電話一起工作，以制定一項計劃來滿足您的健康照護需求。 **請用姓名首字母簽名，表示您已閱讀並理解以上內容：** _____	

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Health Risk Assessment

Member's Name:	**Member's Home Phone:**
	Member's Cell Phone:
Person Completing this Survey:	**Member's Healthcare ID:**
Phone for Person Completing the Survey:	**Member's Date of Birth:** / /
Relationship to Member:	**Today's Date:** / /

	QUESTION	RESPONSE
1.	Do you have a language need other than English?	☐ Arabic ☐ Creole ☐ French ☐ Mandarin ☐ Russian ☐ Somali ☐ Spanish ☐ Vietnamese ☐ None ☐ Other Language
2.	If Other Language, please describe:	
3.	Do you have any special preferences we should be aware of?	Check all that apply: ☐ Cultural Preferences Expand on any cultural preferences: _____ ☐ Hearing Impairment Expand on any hearing impairment preferences: _____ ☐ Literacy Expand on any literacy preferences: _____ ☐ Religion/Spiritual Needs or Preferences Expand on any Religion/Spiritual needs or preferences:

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		_____ ☐ Visual Impairment Expand on any visual impairment preferences: _____ ☐ Other Special Preferences Expand on any special preferences: _____ ☐ None
4.	What is your **main** health concern right now?	
5.	Are you pregnant?	☐ Yes ☐ No ☐ Not Applicable
6.	Do you have any problems with your lungs, like asthma, chronic obstructive pulmonary disease or cystic fibrosis?	☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Cystic Fibrosis ☐ None
7.	Do you have any problems with your heart or circulation like atrial fibrillation, coronary artery disease, peripheral arterial disease, congestive heart failure or stroke?	☐ Atrial Fibrillation ☐ Coronary Artery Disease/ Peripheral Arterial Disease ☐ Congestive Heart Failure ☐ Cerebral Vascular Accident/Stroke ☐ Hypertension ☐ None
8.	Do you have any problems with your kidneys like chronic kidney disease or end stage renal disease on dialysis?	☐ Chronic Kidney Disease ☐ End Stage Renal Disease on Dialysis ☐ None

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9.	Has your doctor diagnosed you with a behavioral health condition such as depression, schizophrenia or bipolar disorder?	☐ Depression ☐ Schizophrenia ☐ Bipolar ☐ None
10.	Do you have any conditions affecting your brain like seizures, memory (dementia) or stroke?	☐ Seizures ☐ Cerebral Vascular Accident/Stroke ☐ Dementia ☐ Alzheimer's Disease ☐ Other brain conditions: _____ ☐ None
11.	Do you have cirrhosis?	☐ Yes ☐ No
12.	Do you have sickle cell?	☐ Yes ☐ No
13.	Do you have HIV or AIDS?	☐ HIV ☐ AIDS ☐ Neither
14.	Do you have active cancer that is being treated with chemo, radiation or surgery?	☐ Yes ☐ No
15.	Do you have diabetes (sugars)?	☐ Yes ☐ No
16.	Do you have rheumatoid arthritis?	☐ Yes ☐ No
17.	Other conditions	☐ Other _____ _____ ☐ None
18.	Have you visited the emergency room in the past 6 months?	☐ Yes ☐ No

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	a) If yes, how many emergency room visits?	
	b) Reason(s) for ER visit(s):	
19.	Have you stayed overnight in the hospital in the past 6 months?	☐ Yes ☐ No
	a) If yes, how many hospital stays?	
	b) If yes, reason(s) for hospital stay(s):	
20.	Do you understand what your medications are for and why you are taking them?	☐ Yes ☐ No ☐ No prescribed medications ✓ If No, we recommend: • Putting your medications in a "Brown Bag" and taking them to your next doctor's appointment. OR • Calling our pharmacist at (855) 658-0918, TTY: 711, Monday – Friday, 8 a.m. – 5 p.m., who will review your medications with you and answer any questions.
21.	Do you need help taking your medicines?	☐ Yes ☐ No
22.	Do you need help filling out health forms?	☐ Yes ☐ No
23.	Do you need help answering questions during a doctor's visit?	☐ Yes ☐ No

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24.	Compared to others your age, would you say your health is:	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
25.	Have you had any changes in thinking, remembering, or making decisions?	☐ Yes ☐ No
26.	Have you received your flu shot this year?	☐ Yes ☐ No
27.	What is your current living situation?	☐ Homeless ☐ Live alone ☐ Live in a group home ☐ Live in a nursing facility ☐ Live in a shelter ☐ Live in an assisted living facility ☐ Live with other family ☐ Live with others unrelated ☐ Live with spouse ☐ Live in out of home placement ☐ Live in out of state medical facility ☐ None of the above ☐ Other
	a) If Other, please describe:	
28.	Can you live safely and move easily around in your home?	☐ Yes ☐ No
29.	If No, does the place where you live have:	

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	a) Good lighting	☐ Yes ☐ No
	b) Good heating	☐ Yes ☐ No
	c) Good cooling	☐ Yes ☐ No
	d) Rails for any stairs or ramps	☐ Yes ☐ No ☐ N/A – There are no stairs or ramps.
	e) Hot water	☐ Yes ☐ No
	f) Indoor toilet	☐ Yes ☐ No
	g) A door to the outside the locks	☐ Yes ☐ No
	h) Stairs to get into your home or stairs inside your home	☐ Yes ☐ No
	i) Elevator	☐ Yes ☐ No
	j) Space to use a wheelchair	☐ Yes ☐ No ☐ N/A – I do not require a wheelchair.
	k) Clear ways to exit your home	☐ Yes ☐ No
30.	Have you fallen in the last month?	☐ Yes ☐ No
31.	Are you afraid of falling?	☐ Yes ☐ No
32.	Do you need help with any of these actions shown below?	
	a) Taking a bath or shower	☐ Yes ☐ No
	b) Going up stairs	☐ Yes ☐ No

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	c) Eating	☐ Yes ☐ No
	d) Getting Dressed	☐ Yes ☐ No
	e) Brushing teeth, brushing hair, shaving	☐ Yes ☐ No
	f) Making meals or cooking	☐ Yes ☐ No
	g) Getting out of a bed or a chair	☐ Yes ☐ No
	h) Shopping and getting food	☐ Yes ☐ No
	i) Using the toilet	☐ Yes ☐ No
	j) Walking	☐ Yes ☐ No
	k) Washing dishes or clothes	☐ Yes ☐ No
	l) Writing checks or keeping track of money	☐ Yes ☐ No
	m) Getting a ride to the doctor or to see your friends	☐ Yes ☐ No
	n) Doing house or yard work	☐ Yes ☐ No
	o) Going out to visit family or friends	☐ Yes ☐ No
	p) Using the phone	☐ Yes ☐ No
	q) Keeping track of appointments	☐ Yes ☐ No
33.	If yes to any of the above, are you getting all the help you need with these actions?	☐ Yes ☐ No
34.	Do you have family members or others willing and able to help you when you need it?	☐ Yes ☐ No

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Health Risk Assessment

35.	Do you ever think your caregiver has a hard time giving you all the help you need?	☐ Yes ☐ No ☐ I do not have a caregiver.
36.	Do you sometimes run out of money to pay for food, rent, bills, and medicine?	☐ Yes ☐ No
37.	Is anyone using your money without your ok?	☐ Yes ☐ No
38.	An advanced directive is a form that lets your loved ones know your health care choices if you are too sick to make them yourself. Do you have a living will or an advanced directive in place?	☐ Yes ☐ No
	a) If Yes, what type of document is it?	
	b) If Yes, does your PCP/Doctor have a copy?	☐ Yes ☐ No
	c) If No, could I send you more information?	☐ Yes ☐ No
39.	(For Questions 39 through 44, only answer if 13 years or older) In the last three months, have you felt you should cut down or stop drinking or using drugs?	☐ Yes ☐ No
40.	In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?	☐ Yes ☐ No
41.	In the last three months, have you felt guilty or bad about how much you drink or use drugs?	☐ Yes ☐ No

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Health Risk Assessment

42.	In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?	☐ Yes ☐ No
43.	Do you feel like you have a problem with drugs or alcohol?	☐ Yes ☐ No
44.	If yes to question 39-43, do you want a Case Manager to call you to provide support/education?	☐ Yes ☐ No
45.	Over the last 2 weeks, how often have you had little interest or pleasure in doing things?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
46.	Over the last 2 weeks, how often have you been feeling down, depressed or hopeless?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
47.	Over the past month (30 days), how many days have you felt lonely?	☐ None – I never feel lonely ☐ Less than 5 days ☐ More than half the days (more than 15) ☐ Most days – I always feel lonely
48.	Are you afraid of anyone or is anyone hurting you?	☐ Yes ☐ No

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	Thank you for taking the time to complete the survey. Someone may be reaching out to you. If you need a little extra help taking care of your health, we could discuss your needs in an "Interdisciplary Care Team" or what we also call an "ICT" meeting. We would include the members of your care team, for example your primary care doctor, your case manager, your caregiver, and yourself. This team can meet in person or by phone and work together to come up with a plan to meet your health care needs. **Please initial that you have read and understood the above: _____**

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Медицинский опросник

Фамилия и имя участника:	**Домашний телефон участника:** **Мобильный телефон участника:**
Лицо, заполняющее эту анкету:	**Медицинский страховой номер участника:**
Телефон лица, заполняющего анкету:	**Дата рождения участника:** / /
Степень родства с участником:	**Сегодняшняя дата:** / /

	ВОПРОС	**ОТВЕТ**
1.	Вам нужен перевод на язык, отличный от английского?	☐ Арабский ☐ Креольский ☐ Французский ☐ Китайский (Mandarin) ☐ Русский ☐ Сомалийский ☐ Испанский ☐ Вьетнамский ☐ Не нужен ☐ Другой язык
2.	Если вы ответили «Другой язык», уточните:	
3.	Есть ли у вас какие-либо особые предпочтения, о которых нам следует знать?	Отметьте все соответствующие варианты: ☐ Культурные предпочтения Опишите подробно культурные предпочтения: _____ ☐ Нарушение слуха Опишите подробно предпочтения в связи с нарушением слуха: _____ ☐ Уровень грамотности Опишите подробно предпочтения в связи с уровнем грамотности _____

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		☐ Религиозные/духовные потребности или предпочтения Опишите подробно религиозные/духовные потребности или предпочтения: _____ ☐ Нарушение зрения Опишите подробно предпочтения в связи с нарушением зрения: _____ ☐ Прочие особые предпочтения Опишите подробно прочие особые предпочтения _____ ☐ Нет особых предпочтений
4.	Что вас беспокоит сейчас **больше всего**?	
5.	Вы беременны?	☐ Да ☐ Нет ☐ Неприменимо
6.	Есть ли у вас заболевания легких, такие как астма, хроническая обструктивная болезнь легких или муковисцидоз?	☐ Астма ☐ Хроническая обструктивная болезнь легких (ХОБЛ) ☐ Муковисцидоз ☐ Нет
7.	Есть ли у вас заболевания сердца или кровообращения, такие как фибрилляция предсердий, коронарная недостаточность, заболевание периферических артерий,	☐ Фибрилляция предсердий ☐ Коронарная недостаточность/заболевание

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	застойная сердечная недостаточность или инсульт?	периферических артерий ☐ Застойная сердечная недостаточность ☐ Острое нарушение мозгового кровообращения/инсульт ☐ Артериальная гипертензия ☐ Нет
8.	Есть ли у вас заболевания почек, такие как хроническая болезнь почек или терминальная стадия почечной недостаточности, требующая диализа?	☐ Хроническая болезнь почек ☐ Терминальная стадия почечной недостаточности, требующая диализа ☐ Нет
9.	Диагностировал ли вам ваш врач расстройство психического здоровья, такое как депрессия, шизофрения или биполярное расстройство?	☐ Депрессия ☐ Шизофрения ☐ Биполярное расстройство ☐ Не диагностировал
10.	Есть ли у вас какие-либо заболевания, влияющие на мозг, такие как судорожные припадки, расстройство памяти (деменция) или инсульт?	☐ Судорожные припадки ☐ Острое нарушение мозгового кровообращения/инсульт ☐ Деменция ☐ Болезнь Альцгеймера ☐ Другие заболевания мозга: _____ ☐ Нет
11.	Есть ли у вас цирроз печени?	☐ Да ☐ Нет
12.	Есть ли у вас серповидноклеточная анемия?	☐ Да ☐ Нет

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13.	Есть ли у вас ВИЧ или СПИД?	☐ ВИЧ ☐ СПИД ☐ Ни того, ни другого
14.	Есть ли у вас активный рак, для лечения которого используется химиотерапия, лучевая терапия или хирургия?	☐ Да ☐ Нет
15.	Есть ли у вас диабет (сахарный)?	☐ Да ☐ Нет
16.	Есть ли у вас ревматоидный артрит?	☐ Да ☐ Нет
17.	Другие заболевания	☐ Другое _____ _____ ☐ Ни одного
18.	Попадали ли вы в отделение неотложной помощи за последние 6 месяцев?	☐ Да ☐ Нет
	a) Если вы ответили «Да», то сколько раз вы пребывали в отделении неотложной помощи?	
	b) Причина(-ы) пребывания в отделении неотложной помощи:	
19.	Вы оставались в больнице на ночь в течение последних 6 месяцев?	☐ Да ☐ Нет
	a) Если вы ответили «Да», то сколько раз вы пребывали в больнице?	
	b) Если вы ответили «Да», укажите причину(-ы) пребывания в больнице:	

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20.	Вы понимаете, для чего нужны ваши лекарства и зачем вы их принимаете?	☐ Да ☐ Нет ☐ Мне не прописаны лекарства ✓ Если вы ответили «Нет», мы рекомендуем: • Положить свои лекарства в пакет и взять их с собой на следующий прием к врачу. ИЛИ • Позвонить нашему фармацевту по телефону (855) 658-0918; телетайп: 711, с понедельника по пятницу, с 8:00 до 17:00. И наш фармацевт обсудит с вами назначенные вам лекарства и ответит на любые вопросы.
21.	Вам нужна помощь при приеме лекарств?	☐ Да ☐ Нет
22.	Вам нужна помощь в заполнении медицинских форм?	☐ Да ☐ Нет
23.	Вам нужна помощь в том, чтобы отвечать на вопросы врача во время визита?	☐ Да ☐ Нет
24.	Вы считаете, что ваше здоровье, по сравнению с вашими ровесниками:	☐ Отличное ☐ Очень хорошее ☐ Хорошее ☐ Удовлетворительное ☐ Плохое
25.	У вас были какие-либо изменения в мышлении, запоминании или принятии решений?	☐ Да ☐ Нет
26.	Вам делали прививку от гриппа в этом году?	☐ Да ☐ Нет

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27.	Каковы ваши текущие условия проживания?	☐ Бездомный(-ая) ☐ Живу один (одна) ☐ Живу в кооперативном жилье ☐ Живу в учреждении сестринского ухода ☐ Живу в приюте ☐ Живу в доме престарелых ☐ Живу с другой семьей ☐ Живу с другими людьми, не являющимися мне родственниками ☐ Живу с супругом(-ой) ☐ Живу вне своего дома ☐ Живу в медицинском учреждении за пределами штата ☐ Ни один из указанных вариантов ☐ Другое
	a) Если вы ответили «Другое», уточните:	
28.	Удается ли вам жить в безопасности и легко передвигаться по дому?	☐ Да ☐ Нет
29.	Если вы ответили «Нет», то имеется ли в месте вашего проживания:	
	a) Хорошее освещение	☐ Да ☐ Нет
	b) Хорошее отопление	☐ Да ☐ Нет
	c) Хорошее кондиционирование	☐ Да ☐ Нет

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	d) Поручни на всех лестницах и пандусах	☐ Да ☐ Нет ☐ Не применимо — в моем жилище нет лестниц и пандусов.
	e) Горячая вода	☐ Да ☐ Нет
	f) Туалет внутри помещения	☐ Да ☐ Нет
	g) Дверь на улицу с замком	☐ Да ☐ Нет
	h) Лестница для входа в дом или лестница внутри дома	☐ Да ☐ Нет
	i) Лифт	☐ Да ☐ Нет
	j) Пространство для использования инвалидной коляски	☐ Да ☐ Нет ☐ Не применимо — мне не нужна инвалидная коляска.
	k) Свободный проход для выхода из дома	☐ Да ☐ Нет
30.	Случалось ли вам падать за последний месяц?	☐ Да ☐ Нет
31.	Вы боитесь упасть?	☐ Да ☐ Нет
32.	Вы нуждаетесь в помощи, совершая какое-либо из указанных ниже действий?	
	a) Принятие ванны или душа	☐ Да ☐ Нет
	b) Подъем по лестнице	☐ Да ☐ Нет
	c) Прием пищи	☐ Да ☐ Нет
	d) Одевание	☐ Да ☐ Нет

	e) Чистка зубов, расчесывание, бритье	☐ Да ☐ Нет
	f) Приготовление пищи	☐ Да ☐ Нет
	g) Вставание с кровати или стула	☐ Да ☐ Нет
	h) Совершение покупок и получение еды	☐ Да ☐ Нет
	i) Пользование туалетом	☐ Да ☐ Нет
	j) Ходьба	☐ Да ☐ Нет
	k) Мытье посуды или стирка	☐ Да ☐ Нет
	l) Выписывание чеков или учет и контроль денежных средств	☐ Да ☐ Нет
	m) Поездка к врачу или к друзьям	☐ Да ☐ Нет
	n) Работа по дому или во дворе	☐ Да ☐ Нет
	o) Поход в гости к семье или друзьям	☐ Да ☐ Нет
	p) Использование телефона	☐ Да ☐ Нет
	q) Учет и контроль визитов	☐ Да ☐ Нет
33.	Если для какого-нибудь из указаных выше вариантов вы выбрали «Да»: получаете ли вы всю необходимую помощь в совершении этих действий?	☐ Да ☐ Нет
34.	Есть ли у вас члены семьи или другие люди, которые готовы и могут помочь вам, когда вам это нужно?	☐ Да ☐ Нет

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35.	Считали ли вы когда-нибудь, что ухаживающему за вами лицу (опекуну) трудно оказывать вам всю необходимую помощь?	☐ Да ☐ Нет ☐ У меня нет опекуна.
36.	Бывает ли такое, что у вас закончились деньги на еду, оплату проживания, оплату счетов и покупку лекарств?	☐ Да ☐ Нет
37.	Использует ли кто-нибудь ваши деньги без вашего разрешения?	☐ Да ☐ Нет
38.	Расширенная доверенность — это форма, которая позволит вашим близким знать ваши предпочтения в вопросах медицинского обслуживания на случай, если ваше состояние здоровья не позволит сделать выбор самостоятельно. У вас есть медицинское завещание или расширенная доверенность?	☐ Да ☐ Нет
	a) Если вы ответили «Да», то какой именно это документ?	
	b) Если вы ответили «Да», имеется ли копия этого документа у вашего терапевта/врача?	☐ Да ☐ Нет
	c) Если вы ответили «Нет», могу ли я прислать вам дополнительную информацию?	☐ Да ☐ Нет
39.	(Отвечайте на вопросы с 39 по 44, только если возраст — 13 лет и старше) Чувствовали ли вы за последние три месяца, что вам следует сократить или прекратить употребление алкоголя или наркотиков?	☐ Да ☐ Нет

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40.	За последние три месяца кто-нибудь раздражал вас или действовал вам на нервы, говоря, что вам нужно сократить или прекратить употребление алкоголя или наркотиков?	☐ Да ☐ Нет
41.	Было ли у вас за последние три месяца чувство вины или плохое самочувствие из-за количества выпиваемого алкоголя или употребляемых наркотиков?	☐ Да ☐ Нет
42.	Просыпались ли вы за последние три месяца с желанием выпить спиртной напиток или принять наркотики?	☐ Да ☐ Нет
43.	Чувствуете ли вы, что у вас есть проблемы с наркотиками или алкоголем?	☐ Да ☐ Нет
44.	Если хотя бы на один вопрос с 39 по 43 вы ответили «Да», хотите ли вы, чтобы вам позвонил координатор программы медицинского обслуживания и предложил поддержку/тренинг?	☐ Да ☐ Нет
45.	Как часто за последние 2 недели вы не проявляли интереса к любимому делу или не испытывали от него удовольствия?	☐ Такого не было ☐ Несколько дней ☐ Больше половины дней ☐ Почти каждый день
46.	Как часто за последние 2 недели вы ощущали уныние, тоску или безысходность?	☐ Такого не было ☐ Несколько дней ☐ Больше половины дней ☐ Почти каждый день
47.	За последний месяц (30 дней) сколько дней вы ощущали себя одиноко?	☐ Ни одного — я никогда не ощущаю себя одиноко ☐ Менее 5 дней ☐ Более половины дней (более 15)

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		☐ Большинство дней — я всегда ощущаю себя одиноко
48.	Вы кого-нибудь боитесь или кто-либо причиняет вам боль?	☐ Да ☐ Нет
	Благодарим вас за то, что нашли время заполнить анкету. Возможно, с вами свяжутся. Если вам дополнительно нужна небольшая помощь в поддержании своего здоровья, мы могли бы обсудить ваши потребности на консилиуме многопрофильной бригады (Interdisciplary Care Team, ICT). Мы можем подключить к обсуждению членов вашей лечащей бригады, например вашего основного лечащего врача, координатора программы медицинского обслуживания, ухаживающего за вами лица (опекуна) и вас самих. Члены этой бригады могут собираться очно или вести собрание по телефону и в итоге вместе разработать план для удовлетворения ваших потребностей в охране здоровья. **Поставьте свои инициалы в знак того, что вы прочитали и поняли вышеизложенное:** _____	

الصحيي المسح

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هاتف منزل العضو: الهاتف النقال للعضو: معرف الرعاية الصحية للعضو: تاريخ ميلاد العضو: / / تاريخ اليوم/ / :	اسم العضو: الشخص الذي يكمل هذا الاستبيان: هاتف الشخص الذي يكمل الاستبيان: **صلة القرابة بالعضو:**

	السؤال	
☐ العربية ☐ الكريول ☐ الفرنسية ☐ الماندرين ☐ الروسية ☐ الصومالية ☐ الإسبانية ☐ الفيتنامية ☐ لايوجد ☐ لغة أخرى	هل لديك حاجة للغة غير الإنجليزية؟	.1
	إن كانت هنالك لغة أخرى، فصِف رجاءً:	.2
أشر كل ما ينطبق: ☐ التفضيلات الثقافية توسع في أي تفضيلات ثقافية: _____ ☐ الإعاقة السمعية توسع في أي إعاقة سمعية التفضيلات: _____ ☐ الثقافة توسع في أي تفضيلات ثقافية: _____ ☐ الدين/التفضيلات أو الإحتياجات الروحية توسع في أي إحتياجات دينية/روحية أو التفضيلات:	هل لديك أي تفضيلات خاصة يجب أن نكون على دراية بها؟	.3

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_____ ☐ الإعاقة البصرية توسع في أي إعاقة بصرية التفضيلات: _____ ☐ تفضيلات خاصة أخرى توسع في أي تفضيلات خاصة: _____ ☐ لايوجد		
	ماهي مشكلتك الصحية الرئيسية الآن؟	.4
☐ نعم ☐ لا ☐ لاينطبق	هل أنتِ حامل؟	.5
☐ الربو ☐ مرض الانسداد الرئوي المزمن (COPD) ☐ التليف الكيسي ☐ لايوجد	هل لديك أي مشاكل في رئتيك، مثل الربو ومرض الانسداد الرئوي المزمن أو التليف الكيسي؟	.6
☐ رجفان أذيني ☐ مرض الشريان التاجي/مرض لشريان المحيطي ☐ فشل القلب الاحتقاني ☐ حادث الأوعية الدموية الدماغية / السكتة الدماغية ☐ ارتفاع ضغط الدم ☐ لايوجد	هل لديك أي مشاكل في القلب أو الدورة الدموية مثل الرجفان الأذيني أو مرض الشريان التاجي أو مرض الشرايين الطرفية أو فشل القلب الاحتقاني أو السكتة الدماغية؟	.7
☐ فشل كلوي مزمن ☐ المرحلة النهائية من أمراض الكلى والديلزة ☐ لايوجد	هل لديك أي مشاكل في الكلى مثل فشل الكلى المزمن أو المرحلة النهائية من أمراض الكلى والديلزة؟	.8

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☐ الاكتئاب ☐ الفصام ☐ الاضطراب ثنائي القطب؟ ☐ لايوجد	هل قام طبيبك بتشخيص إصابتك بحالة صحية سلوكية مثل الاكتئاب أو الفصام أو الاضطراب ثنائي القطب؟	.9
☐ النوبات ☐ حادث الأوعية الدموية الدماغية / السكتة الدماغية ☐ الخرف ☐ مرض الزهايمر ☐ حالات دماغية أخرى: _____ ☐ لايوجد	هل لديك أي حالات تؤثر على عقلك مثل النوبات أو الذاكرة (الخرف) أو السكتة الدماغية؟	.10
☐ نعم ☐ لا	هل تعاني من تليف الكبد؟	.11
☐ نعم ☐ لا	هل لديك خلية منجلية؟	.12
☐ HIV ☐ AIDS ☐ لست مصاباً بأي منها	هل أنت مصاب بفيروس نقص المناعة البشرية (HIV) أو الإيدز (AIDS)؟	.13
☐ نعم ☐ لا	هل لديك سرطان نشط يتم علاجه بالعلاج الكيماوي أو الإشعاع أو الجراحة؟	.14
☐ نعم ☐ لا	هل أنت مصاب بالسكري (سكريات)؟	.15
☐ نعم ☐ لا	هل أنت مصاب بالتهاب المفاصل الروماتويدي؟	.16
☐ أخرى _____ _____ ☐ لايوجد	حالات أخرى	.17
☐ نعم ☐ لا	هل زرت غرفة الطوارئ في الأشهر الستة الماضية؟	.18

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	أ) إذا كانت الإجابة بنعم، فكم عدد زيارات غرفة الطوارئ؟	
	ب) سبب زيارة (أسباب زيارات) غرفة الطوارئ:	
☐ نعم ☐ لا	هل مكثت ليلة في المستشفى خلال الأشهر الستة الماضية؟	.19
	أ) إذا كانت الإجابة بنعم، فكم عدد مرات الإقامة في المستشفى؟	
	ب) إذا كانت الإجابة بنعم، فماهو سبب/ماهي (أسباب) الإقامة في المستشفى:	
☐ نعم ☐ لا ☐ ليست هنالك أدوية موصوفة ✓ إذا كانت الإجابة بـ لا، فإننا نوصي بما يلي: • وضع أدويتك في "كيس بني" وأخذها إلى موعد طبيبك التالي أو • الاتصال بالصيدلي لدينا على 0918-658 (855)، لمستخدمي الهواتف النصية: 711، من الاثنين إلى الجمعة، 8 صباحًا - 5 مساءً، والذي سيقوم بمراجعة أدويتك معك والإجابة على أية أسئلة.	هل تفهم ما هي الأدوية التي تأخذها ولماذا تأخذها؟	.20
☐ نعم ☐ لا	هل تحتاج إلى مساعدة في أخذ أدويتك؟	.21
☐ نعم ☐ لا	هل تحتاج إلى مساعدة في ملء الاستمارات الصحية؟	.22

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☐ نعم ☐ لا	هل تحتاج إلى مساعدة في الإجابة على الأسئلة أثناء زيارة الطبيب؟	.23
☐ ممتازة ☐ جيدة جداً ☐ جيدة ☐ متوسطة ☐ ضعيفة	مقارنة بالآخرين في عمرك، هل تقول أن صحتك:	.24
☐ نعم ☐ لا	هل لديك أي تغييرات في التفكير أو التذكر أو اتخاذ القرارات؟	.25
☐ نعم ☐ لا	هل تلقيت لقاح الإنفلونزا هذا العام؟	.26
☐ متشرد ☐ تعيش لوحدك ☐ تعيش في منزل جماعي ☐ تعيش في مرفق للتمريض ☐ تعيش في ملجأ ☐ تعيش في مرفق للمعيشة بمساعدة ☐ تعيش مع عائلة أخرى ☐ تعيش مع آخرين غير الأقرباء ☐ تعيش مع زوج ☐ تعيش في موضع خارج المنزل ☐ العيش في منشأة طبية خارج الولاية ☐ ولا واحدة من المذكورة أعلاه ☐ أخرى	ما هو وضعك المعيشي الحالي؟	.27
	أ) إذا كان غير ذلك، فصِف رجاءً:	
☐ نعم ☐ لا	هل يمكنك العيش بأمان والتنقل بسهولة في منزلك؟	.28

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	إذا كانت الإجابة بـ لا ، فهل يوجد في المكان الذي تعيش فيه:	.29
☐ نعم ☐ لا	أ) إضاءة جيدة	
☐ نعم ☐ لا	ب) تدفئة جيدة	
☐ نعم ☐ لا	جـ) تبريد جيد	
☐ نعم ☐ لا ☐ لايوجد - لا توجد سلالم أو منحدرات.	د) قضبان لأي سلالم أو منحدرات	
☐ نعم ☐ لا	هـ) الماء الساخن	
☐ نعم ☐ لا	و) مرحاض داخلي	
☐ نعم ☐ لا	ز) باب للخارج يمكن إقفاله	
☐ نعم ☐ لا	ح) سلالم للدخول إلى منزلك أو سلالم داخل منزلك	
☐ نعم ☐ لا	ت) مصعد	
☐ نعم ☐ لا ☐ غير موجود – أنا لا أحتاج إلى كرسي متحرك.	ي) مساحة لاستخدام كرسي متحرك	
☐ نعم ☐ لا	ك) طرق واضحة للخروج من منزلك	
☐ نعم ☐ لا	هل سقطت في الشهر الماضي؟	.30
☐ نعم ☐ لا	هل انت خائف من السقوط؟	.31
	هل تحتاج إلى مساعدة في أي من هذه الإجراءات الموضحة أدناه؟	.32
☐ نعم ☐ لا	a) أخذ حمام أو دش	

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☐ نعم ☐ لا	b) صعود الدرج	
☐ نعم ☐ لا	c) تناول الطعام	
☐ نعم ☐ لا	d) إرتداء الملابس	
☐ نعم ☐ لا	e) تنظيف الأسنان، تمشيط الشعر، الحلاقة	
☐ نعم ☐ لا	f) تحضير الوجبات أو الطبخ	
☐ نعم ☐ لا	g) النهوض من السرير أو الكرسي	
☐ نعم ☐ لا	h) التسوق والحصول على الطعام	
☐ نعم ☐ لا	i) استخدام المرحاض	
☐ نعم ☐ لا	j) المشي	
☐ نعم ☐ لا	k) غسل الأطباق أو الملابس	
☐ نعم ☐ لا	l) كتابة الشيكات أو تتبع الأموال	
☐ نعم ☐ لا	m) الحصول على توصيلة إلى الطبيب أو لرؤية أصدقائك	
☐ نعم ☐ لا	n) القيام بأعمال المنزل أو الفناء	
☐ نعم ☐ لا	o) الخروج لزيارة العائلة أو الأصدقاء	
☐ نعم ☐ لا	p) إستخدام الهاتف	
☐ نعم ☐ لا	q) تتبع المواعيد	
☐ نعم ☐ لا	إذا كانت الإجابة بنعم على أي مما سبق، فهل تحصل على كل المساعدة التي تحتاجها للقيام بتلك الأعمال؟	.33
☐ نعم ☐ لا	هل لديك أفراد من العائلة أو آخرون مستعدون وقادرون على تقديم المساعدة لك عندما تحتاج إليها؟	.34

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☐ نعم ☐ لا ☐ ليس لدي مقدم رعاية.	هل إعتقدت يومًا بأن مقدم الرعاية الخاص بك يواجه صعوبة في تقديم كل المساعدة التي تحتاجها؟	.35
☐ نعم ☐ لا	هل ينفد منك المال أحيانًا عندما تكون بحاجة لدفع ثمن الطعام والإيجار والفواتير والأدوية؟	.36
☐ نعم ☐ لا	هل يستخدم أي شخص أموالك بدون موافقتك؟	.37
☐ نعم ☐ لا	الإرشادات المُعطاة مقدماً هي استمارة تسمح لأحبائك بمعرفة خياراتك المتعلقة بالرعاية الصحية إذا كنت مريضًا جدًا بحيث لا تستطيع الإفصاح عن خياراتك بنفسك. هل لديك وصية حية موضوعة أو إرشادات معطاة مقدماً؟	.38
	أ) إذا كانت الإجابة بنعم، فماهو نوع المستند؟	
☐ نعم ☐ لا	ب) إذا كانت الإجابة بنعم، فهل يمتلك موفر الرعاية الرئيسية/الطبيب الخاص بك نسخة؟	
☐ نعم ☐ لا	جـ) إذا كانت الإجابة لا، فهل يمكنني إرسال المزيد من المعلومات؟	
☐ نعم ☐ لا	(بالنسبة للأسئلة من 39 إلى 44، أجب فقط إذا كان عمرك 13 عامًا أو أكبر) هل شعرت في الأشهر الثلاثة الماضية أنه يجب عليك التقليل من الشرب أو التوقف عنه أو عن تعاطي العقاقير؟	.39
☐ نعم ☐ لا	هل أزعجك أي شخص أو أثار أعصابك في الأشهر الثلاثة الماضية بإخبارك بالتوقف عن الشرب أو عن تعاطي العقاقير؟	.40
☐ نعم ☐ لا	هل شعرت في الأشهر الثلاثة الماضية بالذنب أو بالسوء حيال مقدار ما تشربه أو ما تتعاطاه من عقاقير؟	.41

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☐ نعم ☐ لا	هل كنت تستيقظ في الأشهر الثلاثة الماضية وترغب في تناول مشروب كحولي أو في تعاطي العقاقير؟	.42
☐ نعم ☐ لا	هل تشعر أن لديك مشكلة مع العقاقير أو الكحول؟	.43
☐ نعم ☐ لا	إذا كانت الإجابة بنعم على الأسئلة 39-43، فهل تريد من مدير الحالة الاتصال بك لتقديم الدعم/ التعليم؟	.44
☐ ولامرة ☐ بضعة أيام ☐ أكثر من نصف الأيام ☐ تقريباً كل يوم	كم مرة على مدار الأسبوعين الماضيين كان لديك القليل من الاهتمام أو المتعة في القيام بالأشياء؟	.45
☐ ولامرة ☐ بضعة أيام ☐ أكثر من نصف الأيام ☐ تقريباً كل يوم	كم مرة شعرت فيها بالإحباط أو الاكتئاب أو اليأس على مدار الأسبوعين الماضيين؟	.46
☐ لايوجد - أنا لا أشعر بالوحدة أبداً ☐ أقل من 5 أيام ☐ أكثر من نصف الأيام (أكثر من 15) ☐ معظم الأيام - أنا أشعر بالوحدة دائماً	على مدار الشهر الماضي (30 يومًا)، كم عدد الأيام التي شعرت فيها بالوحدة؟	.47
☐ نعم ☐ لا	هل أنت خائف من أي شخص أو هل هنالك شخص يؤذيك؟	.48

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شكرا لك على الوقت الذي قضيته في إكمال الاستبيان. قد يقوم شخص ما بالتواصل معك. إذا كنت بحاجة إلى القليل من المساعدة الإضافية للاعتناء بصحتك، فيمكننا مناقشة احتياجاتك في إجتماع فريق الرعاية متعدد التخصصات "Interdisciplary Care Team" أو ما نسميه أيضًا باجتماع "ICT". سنقوم بتضمين أعضاء فريق رعايتك، كطبيب الرعاية الأولية ومدير حالتك ومقدم الرعاية و أنت نفسك. يمكن لهذا الفريق الاجتماع شخصيًا أو عبر الهاتف والعمل معًا للتوصل إلى خطة لتلبية احتياجات الرعاية الصحية الخاصة بك. يرجى وضع الأحرف الأولية من اسمك لتأكيد أنك قرأت وفهمت ما ورد أعلاه:_____	

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Encuesta de Salud

Nombre del miembro: **Nombre de la persona que completa la encuesta:** **N.º de teléfono de la persona que completa la encuesta:** **Relación con el miembro:**	**N.º de teléfono fijo del miembro:** **N.º de teléfono celular del miembro:** **N.º de Id. de atención médica del miembro:** **Fecha de nacimiento del miembro:** / / **Fecha de hoy:** / /

	PREGUNTA	RESPUESTA
1.	¿Necesita utilizar otro idioma distinto del español?	☐ Árabe ☐ Creole ☐ Francés ☐ Mandarín ☐ Ruso ☐ Somalí ☐ Inglés ☐ Vietnamita ☐ Ninguno ☐ Otro idioma
2.	Si necesita utilizar otro idioma, indíquelo:	
3.	¿Tiene preferencias especiales que deberíamos conocer?	Marque todas las casillas que correspondan: ☐ Preferencias culturales Indique cuáles: _____ ☐ Preferencias relativas a una discapacidad auditiva Indique cuáles: _____ ☐ Preferencias relativas a la alfabetización Indique cuáles: _____

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		☐ Necesidades o preferencias religiosas/espirituales Indique cuáles: _____ ☐ Preferencias relativas a una discapacidad visual Indique cuáles: _____ ☐ Otras preferencias especiales Indique cuáles: _____ ☐ Ninguna
4.	En este momento, ¿cuál es su **principal** inquietud en relación con su salud?	
5.	¿Está embarazada?	☐ Sí ☐ No ☐ No corresponde
6.	¿Tiene algún problema pulmonar, como asma, enfermedad pulmonar obstructiva crónica o fibrosis quística?	☐ Asma ☐ Enfermedad pulmonar obstructiva crónica (EPOC) ☐ Fibrosis quística ☐ Ninguno
7.	¿Tiene algún problema cardíaco o circulatorio, como fibrilación auricular, arteriopatía coronaria, enfermedad arterial periférica, insuficiencia cardíaca congestiva o accidente cerebrovascular?	☐ Fibrilación auricular ☐ Arteriopatía coronaria o enfermedad arterial periférica ☐ Insuficiencia cardíaca congestiva ☐ Accidente cerebrovascular o apoplejía

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		☐ Hipertensión ☐ Ninguno
8.	¿Tiene algún problema renal, como enfermedad renal crónica o enfermedad renal terminal en diálisis?	☐ Enfermedad renal crónica ☐ Enfermedad renal terminal en diálisis ☐ Ninguno
9.	¿Su médico le ha diagnosticado alguna enfermedad mental, como depresión, esquizofrenia o trastorno bipolar?	☐ Depresión ☐ Esquizofrenia ☐ Trastorno bipolar ☐ Ninguna
10.	¿Tiene alguna afección que le afecte el cerebro, como convulsiones, lagunas de memoria (demencia) o accidente cerebrovascular?	☐ Convulsiones ☐ Accidente cerebrovascular o apoplejía ☐ Demencia ☐ Enfermedad de Alzheimer ☐ Otras afecciones cerebrales: _____ ☐ Ninguna
11.	¿Tiene cirrosis?	☐ Sí ☐ No
12.	¿Tiene enfermedad de células falciformes?	☐ Sí ☐ No
13.	¿Tiene VIH o sida?	☐ VIH ☐ Sida ☐ Ninguno
14.	¿Tiene cáncer activo en tratamiento con quimioterapia, radiación o cirugía?	☐ Sí ☐ No
15.	¿Tiene diabetes (alto nivel de azúcar en sangre)?	☐ Sí ☐ No
16.	¿Tiene artritis reumatoide?	☐ Sí ☐ No

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Encuesta de Salud

17.	Otras afecciones	☐ Otra _____ _____ ☐ Ninguna
18.	¿Tuvo que ir a una sala de urgencias en los últimos seis meses?	☐ Sí ☐ No
	a) Si respondió que sí, ¿cuántas veces tuvo que ir?	
	b) Indique los motivos por los que tuvo que ir a la sala de urgencias:	
19.	¿Ha estado hospitalizado en los últimos seis meses?	☐ Sí ☐ No
	a) Si respondió que sí, ¿cuántas veces lo hospitalizaron?	
	b) Si respondió que sí, indique el motivo de las hospitalizaciones:	

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20.	¿Sabe usted para qué afecciones están indicados los medicamentos que usted toma y por qué se los han recetado?	☐ Sí ☐ No ☐ No tomo medicamentos recetados ✓ Si respondió que no, le recomendamos lo siguiente: • Coloque sus medicamentos en una bolsa de papel y llévela a la próxima consulta médica. O • Comuníquese con nuestro farmacéutico al (855) 658-0918, TTY: 711, de lunes a viernes, de 8 a. m. a 5 p. m., quien analizará los medicamentos junto a usted y responderá sus preguntas.
21.	¿Necesita ayuda para tomar sus medicamentos?	☐ Sí ☐ No
22.	¿Necesita ayuda para rellenar los formularios de salud?	☐ Sí ☐ No
23.	¿Necesita ayuda para responder preguntas durante una consulta médica?	☐ Sí ☐ No
24.	En comparación con otras personas de su edad, usted diría que su salud es:	☐ Excelente ☐ Muy buena ☐ Buena ☐ Regular ☐ Mala
25.	¿Ha observado algún cambio en la forma en que piensa, recuerda o toma decisiones?	☐ Sí ☐ No
26.	¿Recibió la vacuna antigripal este año?	☐ Sí ☐ No
27.	¿Cuál es su situación actual de vivienda?	☐ No tiene hogar

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		☐ Vive solo ☐ Vive en un hogar compartido ☐ Vive en una residencia para personas de la tercera edad ☐ Vive en un albergue ☐ Vive en una residencia con atención personalizada ☐ Vive con otra familia ☐ Vive con personas ajenas a su entorno cercano ☐ Vive con su cónyuge ☐ Vive en una residencia fuera de su hogar ☐ Vive en un centro médico fuera del estado ☐ Ninguna de las opciones anteriores ☐ Otra opción
	a) Si marcó "Otra opción", descríbala:	
28.	¿Puede vivir seguro y desplazarse fácilmente en su hogar?	☐ Sí ☐ No
29.	Si respondió que no, ¿el lugar donde vive tiene...?	
	a) Buena iluminación	☐ Sí ☐ No
	b) Buena calefacción	☐ Sí ☐ No
	c) Buena refrigeración	☐ Sí ☐ No
	d) Barandas para escaleras o rampas	☐ Sí ☐ No ☐ N/C. No hay escaleras ni rampas.

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	e) Agua caliente	☐ Sí ☐ No
	f) Baño en el interior de la vivienda	☐ Sí ☐ No
	g) Una puerta hacia el exterior con cerradura	☐ Sí ☐ No
	h) Escaleras para ingresar a la vivienda o en su interior	☐ Sí ☐ No
	i) Ascensor	☐ Sí ☐ No
	j) Espacio para usar una silla de ruedas	☐ Sí ☐ No ☐ N/C. No uso silla de ruedas.
	k) Espacios sin obstáculos para salir de la vivienda	☐ Sí ☐ No
30.	¿Se ha caído en el último mes?	☐ Sí ☐ No
31.	¿Tiene miedo de caerse?	☐ Sí ☐ No
32.	¿Necesita ayuda con alguna de las actividades que se enumeran a continuación?	
	a) Darse un baño o una ducha	☐ Sí ☐ No
	b) Subir escaleras	☐ Sí ☐ No
	c) Comer	☐ Sí ☐ No
	d) Vestirse	☐ Sí ☐ No
	e) Lavarse los dientes, peinarse, afeitarse	☐ Sí ☐ No
	f) Prepararse la comida o cocinar	☐ Sí ☐ No
	g) Levantarse de la cama o de una silla	☐ Sí ☐ No

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	h) Hacer las compras o proveerse de alimentos	☐ Sí ☐ No
	i) Ir al baño	☐ Sí ☐ No
	j) Caminar	☐ Sí ☐ No
	k) Lavar los platos o la ropa	☐ Sí ☐ No
	l) Emitir cheques o manejar dinero	☐ Sí ☐ No
	m) Conseguir transporte para ir al médico o visitar amigos	☐ Sí ☐ No
	n) Hacer tareas domésticas o de jardinería	☐ Sí ☐ No
	o) Salir para visitar a sus familiares o amigos	☐ Sí ☐ No
	p) Usar el teléfono	☐ Sí ☐ No
	q) Llevar un registro de sus consultas médicas	☐ Sí ☐ No
33.	Si respondió que sí a alguna de estas preguntas, ¿recibe toda la ayuda que necesita para realizar estas actividades?	☐ Sí ☐ No
34.	¿Tiene familiares u otras personas que deseen y puedan ayudarlo cuando usted lo necesita?	☐ Sí ☐ No
35.	¿Alguna vez pensó que a su cuidador le cuesta brindarle toda la ayuda que usted necesita?	☐ Sí ☐ No ☐ No tengo cuidador.
36.	¿A veces se queda sin dinero para pagar los alimentos, el alquiler, las cuentas y los medicamentos?	☐ Sí ☐ No

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37.	¿Alguien usa su dinero sin su consentimiento?	☐ Sí ☐ No
38.	Una directiva anticipada es un formulario que le permite a sus seres queridos saber cuáles son sus decisiones sobre la atención médica que desea recibir, en caso de que esté demasiado enfermo para tomarlas usted mismo. ¿Tiene un testamento vital o una directiva anticipada?	☐ Sí ☐ No
	a) Si respondió que sí, ¿qué tipo de documento es?	
	b) Si respondió que sí, ¿tienen su médico o proveedor de atención primaria una copia?	☐ Sí ☐ No
	c) Si respondió que no, ¿me permitiría enviarle más información?	☐ Sí ☐ No
39.	(Responda las preguntas 39 a 44 solo si tiene más de 13 años) En los últimos tres meses, ¿ha pensado que debería reducir el consumo de alcohol o drogas, o dejar de consumirlos?	☐ Sí ☐ No
40.	En los últimos tres meses, ¿se ha enojado o molestado con alguien que le haya pedido que reduzca el consumo de alcohol o drogas, o que deje de consumirlos?	☐ Sí ☐ No
41.	En los últimos tres meses, ¿se ha sentido mal o culpable por la cantidad de alcohol o drogas que consume?	☐ Sí ☐ No

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42.	En los últimos tres meses, ¿se ha despertado con ganas de beber alcohol o consumir drogas?	☐ Sí ☐ No
43.	¿Cree que tiene un problema con el consumo de drogas o alcohol?	☐ Sí ☐ No
44.	Si respondió que sí a las preguntas 39 a 43, ¿desea que un administrador de casos se comunique con usted para proporcionarle ayuda o información?	☐ Sí ☐ No
45.	En las últimas dos semanas, ¿con qué frecuencia ha sentido poco interés o placer en hacer cosas?	☐ Ningún día ☐ Varios días ☐ La mitad de los días ☐ Casi todos los días
46.	En las últimas dos semanas, ¿con qué frecuencia se ha sentido sin ánimo, deprimido o desesperanzado?	☐ Ningún día ☐ Muchos días ☐ La mitad de los días ☐ Casi todos los días
47.	En el último mes (30 días), ¿cuántos días se sintió solo?	☐ Ninguno; nunca me siento solo ☐ Menos de cinco días ☐ Más de la mitad de los días (más de 15 días) ☐ La mayoría de los días; siempre me siento solo
48.	¿Le teme a alguien o alguien le hace daño?	☐ Sí ☐ No

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	Gracias por tomarse el tiempo para responder la encuesta. Es posible que alguien se ponga en contacto con usted. Si necesita un ayuda adicional para cuidar su salud, podemos analizar sus necesidades en un "equipo de atención interdisciplinario" o lo que también denominamos una reunión de "ICT". Incluiríamos a los miembros de su equipo de atención, por ejemplo, su médico de atención primaria, su administrador de casos, su cuidador y usted. Este equipo puede reunirse de manera presencial o por teléfono, y trabajar en conjunto para elaborar un plan destinado a satisfacer sus necesidades de atención médica. **Coloque sus iniciales para indicar que ha leído y entendido todo lo anterior. _____**

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سلامت نظرسنجی

شماره تلفن منزل عضو: شماره تلفن همراه عضو: شماره عضویت بیمه فرد عضو: تاریخ تولد عضو: / / تاریخ امروز/ / :	نام عضو: فردی که این پرسشنامه را پر می کند: شماره تماس فردی که پرسشنامه را پر می کند: **رابطه با عضو:**

پاسخ	پرسش	
☐ عربی ☐ کرئول ☐ فرانسوی ☐ چینی مندرین ☐ روسی ☐ سومالی ☐ اسپانیایی ☐ ویتنامی ☐ هیچکدام ☐ زبانی دیگر	آیا به زبان دیگری به جز انگلیسی نیاز دارید؟	.1
	اگر زبان دلخواه در لیست نیست، لطفا نام ببرید:	.2
تمام موارد مورد نیاز را انتخاب کنید: ☐ اولویت های فرهنگی لطفا درباره اولویت های فرهنگی خود توضیح دهید: _____ ☐ اختلال شنوایی لطفا درباره اولویت های اختلال شنوایی توضیح دهید: _____ ☐ سواد لطفا درباره اولویت های مربوط به سواد توضیح دهید: _____ ☐ نیازها یا اولویت های دینی/معنوی لطفا درباره اولویت ها یا نیازهای دینی/معنوی توضیح دهید:	آیا اولویت های خاصی دارید که ما باید از آن ها مطلع باشیم؟	.3

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_____ ☐ اختلال بینایی لطفا درباره اختلال بینایی توضیح دهید: _____ ☐ سایر اولویت های ویژه درباره هرگونه اولویت ویژه توضیح دهید: _____ ☐ هیچ		
	در حال حاضر نگرانی اصلی شما درباره سلامتتان چیست؟	.4
☐ بلی ☐ خیر ☐ شامل من نمی شود	آیا باردار هستید؟	.5
☐ آسم ☐ بیماری انسدادی مزمن ریوی (COPD) ☐ فیبروز کیستیک ☐ هیچکدام	آیا مشکل ریوی دارید؟ مواردی مانند آسم، بیماری انسدادی مزمن ریوی یا فیبروز کیستیک.	.6
☐ فیبریلاسیون دهلیزی ☐ بیماری عروق کرونر/بیماری شریانی محیطی ☐ نارسایی احتقانی قلب ☐ واقعه/سکته مغزی عروقی ☐ فشار خون بالا ☐ هیچکدام	آیا مشکل قلبی یا گردش خون دارید؟ مواردی مانند فیبریلاسیون دهلیزی، بیماری عروق کرونر، بیماری شریانی محیطی، نارسایی احتقانی قلب یا سکته.	.7
☐ بیماری مزمن کلیوی ☐ بیماری کلیوی مرحله نهایی با نیاز به دیالیز	آیا مشکل کلیوی دارید؟ مواردی مانند بیماری مزمن کلیوی یا بیماری کلیوی مرحله نهایی با نیاز به دیالیز.	.8

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☐ هیچکدام		
☐ افسردگی ☐ اسکیزوفرنی ☐ دوقطبی ☐ هیچکدام	آیا پزشک شما بیماری سلامت رفتاری مانند افسردگی، اسکیزوفرنی یا ناهنجاری دوقطبی را در شما تشخیص داده است؟	.9
☐ حملات تشنج ☐ واقعه/سکته مغزی عروقی ☐ فراموشی ☐ بیماری آلزایمر ☐ سایر مشکلات مغزی: _____ ☐ هیچکدام	آیا بیماری دارید که بر روی مغز شما اثر بگذارد؟ مانند تشنج، حافظه (فراموشی) یا سکته؟	.10
☐ بلی ☐ خیر	آیا سیروز دارید؟	.11
☐ بلی ☐ خیر	آیا کم خونی سلول داسی شکل دارید؟	.12
☐ HIV ☐ ایدز ☐ هیچکدام	آیا HIV یا ایدز دارید؟	.13
☐ بلی ☐ خیر	آیا سرطان فعال دارید که با شیمی درمانی، پرتودرمانی یا جراحی در حال درمان است؟	.14
☐ بلی ☐ خیر	آیا دیابت (قند) دارید؟	.15
☐ بلی ☐ خیر	آیا روماتیسم مفصلی دارید؟	.16
☐ غیره _____ _ _____ ☐ هیچکدام	سایر مشکلات	.17

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☐ بلی ☐ خیر	آیا در طی 6 ماه گذشته به اورژانس مراجعه داشته اید؟	.18
	a) اگر بلی، چند بار به اورژانس مراجعه کردید؟	
	b) دلایل مراجعه به اورژانس:	
☐ بلی ☐ خیر	آیا در طی 6 ماه گذشته در بیمارستان بستری شده اید؟	.19
	a) اگر بلی، چند بار در بیمارستان بستری شدید؟	
	b) اگر بلی، دلایل بستری شدن در بیمارستان چه بودند:	
☐ بلی ☐ خیر ☐ داروی تجویزی مصرف نمی کنم ✓ اگر خیر، توصیه می کنیم: • داروهای تجویزی را در یک "کیسه کاغذی" بگذارید و در ملاقات بعدی با پزشک خود آن ها را همراه بیاورید. یا • با شماره 658-0918 (855)، TTY به شماره 711، با پزشک داروساز ما تماس بگیرید، دوشنبه تا جمعه، 8 صبح تا 5 عصر، که می تواند داروهای شما را بررسی کرده و به سوالات شما پاسخ دهد.	آیا می دانید داروهایی که مصرف می کنید برای چه منظوری تجویز شده اند و چرا آن ها را مصرف می کنید؟	.20

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☐ بلی ☐ خیر	آیا در استفاده از داروهای خود نیازمند کمک هستید؟	.21
☐ بلی ☐ خیر	آیا در پر کردن فرم های سلامت نیازمند کمک هستید؟	.22
☐ بلی ☐ خیر	آیا در پاسخ دادن به سوالات در طی ملاقات با پزشک خود نیازمند کمک هستید؟	.23
☐ عالی ☐ خیلی خوب ☐ خوب ☐ متوسط ☐ ضعیف	در مقایسه با همسالان خود، از نظر سلامت چطور هستید:	.24
☐ بلی ☐ خیر	آیا در رابطه با قابلیت های تفکر، به یادآوری، یا تصمیم گیری، در خود تغییری مشاهده کرده اید؟	.25
☐ بلی ☐ خیر	آیا امسال واکسن آنفلوآنزای خود را دریافت کرده اید؟	.26
☐ بی خانمان ☐ زندگی به تنهایی ☐ در یک خانه گروهی ☐ در مرکز پرستاری ☐ در سرپناه ☐ در یک موسسه زندگی همیاری ☐ با سایر اعضای خانواده ☐ با افراد غیر خویشاوند ☐ با همسر ☐ در مراکز اسکان خارج-از-منزل ☐ در موسسه پزشکی دولتی ☐ هیچکدام ☐ غیره	وضعیت کنونی اسکان شما چطور است؟	.27
	a) اگر غیره، لطفا توضیح دهید:	

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☐ بلی ☐ خیر	آیا می توانید در خانه خود با امنیت زندگی کرده و به راحتی حرکت کنید؟	.28
	اگر خیر، آیا جایی که در آن زندگی می کند موارد زیر را دارد:	.29
☐ بلی ☐ خیر	a) روشنایی مناسب	
☐ بلی ☐ خیر	b) گرمایش مناسب	
☐ بلی ☐ خیر	c) سرمایش مناسب	
☐ بلی ☐ خیر ☐ شامل نمیشود- پله یا رمپ نداریم	d) نرده مناسب برای پله ها یا رمپ	
☐ بلی ☐ خیر	e) آب گرم	
☐ بلی ☐ خیر	f) مستراح داخل منزل	
☐ بلی ☐ خیر	g) درب به بیرون و دارای قفل	
☐ بلی ☐ خیر	h) پله برای رسیدن به خانه یا پله درون خانه	
☐ بلی ☐ خیر	i) آسانسور	
☐ بلی ☐ خیر ☐ شامل نمی شود- نیازی به صندلی چرخدار ندارم.	j) فضای کافی برای استفاده از صندلی چرخدار	
☐ بلی ☐ خیر	K) مسیری بدون مانع برای خروج از خانه	
☐ بلی ☐ خیر	آیا در طی ماه گذشته زمین خورده اید؟	.30
☐ بلی ☐ خیر	آیا نگران زمین خوردن هستید؟	.31
	آیا در رابطه با هر یک از موراد زیر نیازمند کمک هستید؟	.32

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☐ بلی ☐ خیر		
☐ بلی ☐ خیر	a) حمام کردن	
☐ بلی ☐ خیر	b) بالا رفتن از پله ها	
☐ بلی ☐ خیر	c) غذا خوردن	
☐ بلی ☐ خیر	d) لباس پوشیدن	
☐ بلی ☐ خیر	e) مسواک زدن، شانه کردن مو، اصلاح صورت	
☐ بلی ☐ خیر	f) آشپزی یا تهیه غذا	
☐ بلی ☐ خیر	g) بلند شدن از تخت یا صندلی	
☐ بلی ☐ خیر	h) خرید آذوقه و غذا	
☐ بلی ☐ خیر	i) استفاده از مستراح	
☐ بلی ☐ خیر	j) راه رفتن	
☐ بلی ☐ خیر	k) شستن ظروف یا لباس	
☐ بلی ☐ خیر	l) نوشتن چک یا حساب و کتاب مالی	
☐ بلی ☐ خیر	m) استفاده از وسایل نقلیه برای رفتن به مطب پزشک یا دیدار دوستان	
☐ بلی ☐ خیر	n) انجام کار خانه یا رسیدگی به حیاط و باغچه	
☐ بلی ☐ خیر	o) رفتن به ملاقات خانواده یا دوستان	
☐ بلی ☐ خیر	p) استفاده از تلفن	
☐ بلی ☐ خیر	q) به یاد داشتن قرارهای ملاقات	

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☐ بلی ☐ خیر	اگر به هر کدام از موارد بالا جواب مثبت داده اید، آیا کمک لازم برای انجام آن ها را دریافت می کنید؟	.33
☐ بلی ☐ خیر	آیا اعضای خانواده یا فرد دیگری هست که بخواهد و قادر باشد در صورت نیاز به شما کمک کند؟	.34
☐ بلی ☐ خیر ☐ مراقب ندارم	آیا گاهی فکر می کنید که فرد مراقب شما در برآورده کردن تمامی نیازهای شما دچار سختی و دشواری است؟	.35
☐ بلی ☐ خیر	آیا پیش آمده است که برای خرید غذا، اجاره، قبوض و دارو دچار کمبود مالی شده باشید؟	.36
☐ بلی ☐ خیر	آیا فردی بدون رضایت شما از پول شما استفاده می کند؟	.37
☐ بلی ☐ خیر	وکالت نامه نوعی سند رسمی است برای مواقعی که به شدت بیمار هستید و نمی توانید برای وضعیت خود تصمیم گیری کنید. در آن تصمیم گیری های مراقبت سلامتی مورد نظر شما ذکر شده است تا اعضای خانواده شما از آن ها مطلع باشند. آیا وصیت نامه یا وکالت نامه تنظیم کرده اید؟	.38
	a) اگر بلی، چه نوع سندی تنظیم کرده اید؟	
☐ بلی ☐ خیر	b) اگر بلی، آیا دکتر/پزشک خانواده شما یک نسخه از آن را دارد؟	
☐ بلی ☐ خیر	c) اگر خیر، می خواهید برای شما اطلاعات بیشتری در این رابطه ارسال کنم؟	

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☐ بلی ☐ خیر	(برای سوالات 39 تا 44، در صورتی پاسخ دهید که سن 13 سال یا بیشتر دارید) در طی سه ماه گذشته، آیا احساس کرده اید که باید مصرف الکل یا مواد مخدر خود را کاهش داده یا متوقف کنید؟	.39
☐ بلی ☐ خیر	در طی سه ماه گذشته، آیا کسی با گوشزد کردن اینکه باید مصرف الکل یا مواد مخدر خود را کاهش داده یا متوقف کنید شما را ناراحت یا عصبانی کرده است؟	.40
☐ بلی ☐ خیر	در طی سه ماه گذشه، آیا درباره میزان مصرف الکل یا مواد مخدر خود احساس شرمساری یا احساس بد داشته اید؟	.41
☐ بلی ☐ خیر	در طی سه ماه گذشته، آیا پس از بیدار شدن احساس نیاز به مصرف نوشیدنی الکلی یا مواد مخدر داشته اید؟	.42
☐ بلی ☐ خیر	آیا احساس می کنید دچار مشکل سوء مصرف مواد مخدر یا الکل هستید؟	.43
☐ بلی ☐ خیر	اگر به سوالات 39 تا 43 جواب مثبت داده اید، آیا می خواهید یک مدیر پرونده با شما تماس گرفته و پشتیبانی/آموزش برای شما فراهم کند؟	.44
☐ به هیچ عنوان ☐ چندین روز ☐ بیش از نیمی از روزها ☐ تقریبا هر روز	در طی 2 هفته گذشته، چه مقدار احساس بی علاقگی به انجام کاری یا عدم لذت بردن از انجام کاری را تجربه کرده اید؟	.45
☐ به هیچ عنوان ☐ چندین روز ☐ بیش از نیمی از روزها ☐ تقریبا هر روز	در طی 2 هفته گذشته، چه مقدار احساس کسلی، افسردگی یا ناامیدی را تجربه کرده اید؟	.46
☐ هیچ - هیچگاه احساس تنهایی نمیکنم ☐ کمتر از 5 روز ☐ بیش از نیمی از روزها (بیش از 15 روز) ☐ بیشتر روزها - همیشه احساس تنهایی می کنم	در طی ماه (30 روز) گذشته، چند روز احساس تنهایی را تجربه کرده اید؟	.47

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سلامت نظرسنجی

.48	آیا از کسی می ترسید یا آیا کسی به شما آسیب می رساند؟	☐ بلی ☐ خیر
	از اینکه زمان خود را صرف پاسخ دادن به این پرسشنامه کردید از شما متشکریم. ممکن است فردی از سوی ما با شما تماس بگیرد. اگر برای مراقبت از سلامت خود نیازمند کمک بیشتری هستید، می توانیم در یک جلسه با "تیم مراقبت های چند رشته ای" یا آنچه ما ICT می نامیم، به بحث درباره نیازهای شما بپردازیم. اعضای تیم مراقبت شما در آن جلسه حضور خواهند داشت، برای مثال پزشک خانواده شما، مدیر پرونده شما، مراقب و خود شما. این تیم می تواند هم به صورت حضوری و هم به صورت تلفنی جلسه ای برگذار نماید تا برنامه ای برای برآورده کردن نیازهای مراقبتی شما تنظیم کنیم. در صورت خواندن و درک مطالب بالا، لطفا حروف اول نام و نام خانوادگی خود را در اینجا ثبت کنید:_____	

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Daim Ntawv Ntsuam Xyuas kev Noj Qab Haus Huv

Tswv Cuab Lub Npe **Tus Neeg Ua Qhov Kev Tshawb Fawb no Tiav** **Tus Neeg Ua Qhov Kev Tshawb Fawb no Tiav Tus Xov Tooj** **Kev Sib Txeeb Ze rau Tus Tswv Cuab:**	**Tswv Cuab Tus Xov Tooj Hauv Tsev:** **Tus Tswv Tus Xov Tooj Ntawm Tes:** **Tswv Cuab Daim Npav Kho Mob Tus ID:** **Tus Tswv Cuab Hnub Yug:** / / **<u>Hnub No Yog Hnub Tim</u>:** / /

	NQE LUS NUG	**NQE LUS TEB**
1.	Koj puas xav tau ib hom lus uas tsis yog lus As Kiv?	☐ Lus Arabic ☐ Lus Creole ☐ Lus Fab Kis ☐ Lus Suav ☐ Lus Lav Xias ☐ Lus Somali ☐ Lus Mev ☐ Lus Nyab Laj ☐ Tsis Muaj Hom Lus ☐ Lwm Hom Lus
2.	Yog teb tias Muaj Lwm Hom Lus, thov piav qhia tias:	
3.	Koj puas muaj tej yam kev nyiam tshwj xeeb uas peb yuav tsum ras nco txog?	Kos rau txhua nqe uas siv tau: ☐ Tej Kab Lis Kev Cai Uas Yog Cov Kev Nyiam Nthuav dav raws li lwm yam kab lis kev cai uas yog kev nyiam: _____ ☐ Kev Hnov Lus Tsis Zoo Nthuav dav raws li lwm yam kev hnov lus tsis zoo cov kev nyiam: _____ ☐ Kev paub ntaub ntawv

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		Nthuav dav raws li tej yam kev paub ntawv uas yog cov kev nyiam: _____ ☐ Kev Ntseeg/Kev Xav Tau Hauv Sab Ntsuj Plig los sis Cov Kev Nyiam Nthuav dav txog qee yam kev ntseeg/sab ntsuj plig kev xav tau los sis cov kev nyiam: _____ ☐ Qhov Muag Tsis Pom Kev Nthuav dav txog qee yam qhov muag tsis pom kev cov kev nyiam: _____ ☐ Lwm Kev Nyiam Tshwj Xeeb Nthuav dav txog qee yam kev nyiam tshwj xeeb: _____ ☐ Tsis muaj
4.	Qhov koj **txhawj xeeb** loj rau kev noj qab haus huv tam sim no yog dab tsi?	
5.	Puas yog koj lub cev xeeb me nyuam?	☐ Yog ☐ Tsis Yog ☐ Tsis Paub Txog Dab Tsis Lis
6.	Koj puas muaj ib yam teeb meem rau koj lub ntsws, xws li hawb pob, kab mob ntsws tsis paub zoo tu qab los sis kab mob ntsws qhuav?	☐ Hawb pob ☐ Kab Mob Ntsws Tsis Paub Zoo Tu Qab (Chronic Obstructive Pulmonary Disease, COPD) ☐ Kab Mob Ntsws Qhuav (Cystic Fibrosis) ☐ Tsis muaj

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7.	Koj puas muaj qee yam teeb meem rau koj lub plawv los sis txoj hlab ntshav plaws tshaws xws li plawv dhia tsis xwm yeem, kab mob txoj hlab ntsha plawv tshaws, kab mob txoj hlab ntsha plawv khub roj, plawv tsis ua hauj lwm los sis mob hlab ntshav tawg?	☐ Plawv Dhia Tsis Xwm Yeem ☐ Kab Mob Hlab Ntsha Plawv Tshaws/Kab Mob Txoj Hlab Ntsha Plawv Khub Roj ☐ Plawv Tsis Ua Hauj Lwm ☐ Txoj Hlab Ntsha Hlwb Tawg/Mob Hlab Ntshav Tawg ☐ Ntshav Siab ☐ Tsis muaj
8.	Koj puas muaj ib qho teeb meem rau koj lub raum xws li tus kab mob raum uas tsis paub zoo tu qab los sis kab mob raum rau qib kawg lawm uas niaj hnub lim ntshav lawm xwb?	☐ Kab Mob Raum Tsis Paub Zoo Tu Qab ☐ Kab Mob Raum Rau Qib Kawg Lawm Uas Niaj Hnub Lim Ntshav Lawm Xwb ☐ Tsis muaj
9.	Koj tus kws kho mob puas tau tshuaj xyuas koj tus mob xws li kev ntxhov siab, kab mob puas hlwb los sis kab mob ua rau hlwb tsis meej pem?	☐ Kev ntxhov siab ☐ Kab mob puas hlwb ☐ Kab mob ua rau hlwb tsis meej pem ☐ Tsis muaj
10.	Koj puas muaj qee yam mob uas cuam tshuam rau koj lub hlwb xws li ua rau qaug dab peg, tsis hnov qab (kab mob hlwb feeb tsis meej) los sis kab mob hlab ntsha tawg?	☐ Qaug dab peg ☐ Hlab Ntshav Hlwb Tawg/Mob Hlab Ntshav Tawg ☐ Kab Mob Hlwb Feeb Tsis Meej ☐ Kab mob Alzheimer ☐ Lwm yam kab mob hlwb: _____ ☐ Tsis muaj
11.	Koj puas muaj tus kab mob siab khov?	☐ Muaj ☐ Tsis Muaj

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12.	Koj puas muaj tus kab mob keeb cell tsis zoo?	☐ Muaj ☐ Tsis Muaj
13.	Koj puas muaj tus kab mob HIV los sis AIDS?	☐ Kab Mob HIV ☐ Kab Mob AIDS ☐ Tsis Muaj Ib Yam Hlo Li
14.	Koj puas muaj ib tug kab mob khees xaws uas tseem tab tom raug kho nrog chemo, hluav taws xob tua los sis phais tus mob tawm?	☐ Muaj ☐ Tsis Muaj
15.	Koj puas muaj kab mob ntshav qab zib (ntshav piam thaj)?	☐ Muaj ☐ Tsis Muaj
16.	Koj puas muaj tus kab mob pob qij txha?	☐ Muaj ☐ Tsis Muaj
17.	Lwm yam teeb meem	☐ Lwm yam _____ _____ ☐ Tsis muaj
18.	Koj puas tau mus tim chav kho mob xwm txheej ceev rau hauv 6 lub hlis dhau los?	☐ Muaj ☐ Tsis Muaj
	a) Yog mus, koj tau mus puas tsawg zaus rau tim chav kho mob xwm txheej ceev?	
	b) Cov laj thawj txhawm rau kev mus tim chav ER:	
19.	Koj puas tau mus pw kho mob rau tim tsev kho mob rau hauv lub sij hawm 6 lub hlis dhau los?	☐ Muaj ☐ Tsis Muaj
	a) Yog mus pw, koj tau mus pw kho mob tim tsev kho mob puas tsawg zaus lawm?	

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	b) Yog mus pw, cov laj thawj txhawm rau kev mus pw kho mob tim tsev kho mob:	
20.	Koj puas nkag siab txog kev siv koj cov tshuaj kho mob thiab vim li cas koj thiaj siv tej tshuaj ntawd?	☐ Muaj ☐ Tsis Muaj ☐ Tsis muaj cov tshuaj uas siv ntaub ntawv yuav ✓ Yog tsis muaj, peb xav qhia tias: • Muab koj cov tshuaj kho mob tso rau hauv "Lub Hnab Daj Lis" thiab nqa cov tshuaj mus rau koj tus kws kho mob ztom ntej kev teem sij hawm. LOS SIS • Hu rau peb tus kws muag tshuaj rau ntawm (855) 658-0918, TTY: 711, Hnub Monday – Hnub Friday, 8 teev sawv ntxov – 5 teev tsaus ntuj, leej twg yuav yog tus los tshuaj xyuas koj cov tshuaj thiab teb qee cov nqe lus nug.
21.	Koj puas xav tau kev pab siv koj cov tshuaj kho mob?	☐ Muaj ☐ Tsis Muaj
22.	Koj puas xav tau kev pab sau cov foos yuav tshuaj?	☐ Muaj ☐ Tsis Muaj
23.	Koj puas xav tau kev pab teb cov nqe lus nug rau thaum koj tus kab mob los ntsib?	☐ Muaj ☐ Tsis Muaj
24.	Yog muab piv rau lwm tus neeg uas muaj hnub nyoog li koj, koj puas hais tau tias koj li kev noj qab haus huv yog:	☐ Zoo Tshaj Plaws ☐ Zoo Heev ☐ Zoo ☐ Siv Tau ☐ Tsis Zoo
25.	Puas muaj tej yam kev hloov pauv rau txoj kev xav, kev nco qab, los sis kev txiav txim siab?	☐ Muaj ☐ Tsis Muaj

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26.	Koj puas tau txhaj tshuaj tiv thaiv kab mob khaub thuas rau xyoo no?	☐ Muaj ☐ Tsis Muaj
27.	Koj lub chaw nyob tam sim no zoo li cas?	☐ Tsis muaj tsev nyob ☐ Nyob ib leeg ☐ Nyob rau hauv ib pawg tsev neeg ua ke ☐ Nyob rau hauv ib lub chav ntawm tu neeg kho mob ☐ Nyob rau hauv ib lub tsev pheeb suab ☐ Nyob hauv ib lub chaw uas muab pab txog kev ua neej nyob ☐ Nyob nrog rau lwm tsev neeg ☐ Nyob nrog rau lwm cov neeg uas tsis sib paub ☐ Nyob nrog rau tus txij nkawm ☐ Nyob rau sab nraum lub tsev nyob ☐ Nyob rau sab nraum lub chaw kho mob hauv xeev ☐ Tsis yog tag nrho cov lus hais los saum toj saud ☐ Lwm yam
	a) Yog Lwm Yam, thov piav qhia:	
28.	Koj puas tuaj yeem nyob tau nyab xeeb thiab txav mus los tau yooj yim rau hauv koj lub tsev?	☐ Muaj ☐ Tsis Muaj
29.	Yog Tsis Nyab Xeeb, lub chaw koj nyob ntawd pua muaj dab tsi xwb:	
	a) Muaj teeb cig zoo	☐ Muaj ☐ Tsis Muaj

	b) Muaj tshuab cua sov zoo	☐ Muaj ☐ Tsis Muaj
	c) Muaj tshuab cua txias zoo	☐ Muaj ☐ Tsis Muaj
	d) Muaj cov las tuav nce ntaiv los sis nqis ntaiv	☐ Muaj ☐ Tsis Muaj ☐ N/A – Tsis muaj cov las tuav nce ntaiv los sis nqis ntaiv.
	e) Muaj dej kub	☐ Muaj ☐ Tsis Muaj
	f) Muaj chav dej nyob rau sab hauv tsev	☐ Muaj ☐ Tsis Muaj
	g) Muaj ib lub qhov rooj uas muaj qhov xauv nyob sab nrauv	☐ Muaj ☐ Tsis Muaj
	h) Muaj cov ntaiv nce nkag los rau hauv koj lub tsev los sis cov ntaiv nce nyob sab hauv koj lub tsev	☐ Muaj ☐ Tsis Muaj
	i) Muaj ntaiv hluas taws xob	☐ Muaj ☐ Tsis Muaj
	j) Muaj chaw siv lub rooj zaum muaj log mus los	☐ Muaj ☐ Tsis Muaj ☐ N/A – Kuv tsis tas siv ib lub rooj zaum muaj log.
	k) Hauv koj lub tsev muaj cov kev tawm mus uas tsis muaj dab tsis thaiv kev	☐ Muaj ☐ Tsis Muaj
30.	Koj puas ntog nyob rau hauv lub hlis dhau los?	☐ Muaj ☐ Tsis Muaj
31.	Koj puas ntshai tsam ntog?	☐ Muaj ☐ Tsis Muaj
32.	Koj puas xav tau kev pab ua tej yam xws li hauv qab no?	

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	a) pab da dej los sis ntxuav ib ce	☐ Muaj ☐ Tsis Muaj
	b) Kev nce ntaiv	☐ Muaj ☐ Tsis Muaj
	c) Kev noj mov	☐ Muaj ☐ Tsis Muaj
	d) Kev Hnag Ris Tsho	☐ Muaj ☐ Tsis Muaj
	e) Kev txhuam hniav, zawv plaub hau, chais plaub hwj txwv	☐ Muaj ☐ Tsis Muaj
	f) Npaj zaub mov los sis ua zaub mov	☐ Muaj ☐ Tsis Muaj
	g) Pab tsa sawv ntawm lub txaj los sis lub rooj zaum muaj log	☐ Muaj ☐ Tsis Muaj
	h) Kev tawm mus yuav khoom thiab nrhiav khoom noj	☐ Muaj ☐ Tsis Muaj
	i) Kev siv chav dej	☐ Muaj ☐ Tsis Muaj
	j) Taug kev mus los	☐ Muaj ☐ Tsis Muaj
	k) Ntxuav twj tais los sis ntxhua khaub ncaws	☐ Muaj ☐ Tsis Muaj
	l) Sau daim nyiaj tshev los sis khaws tej nyiaj txiag	☐ Muaj ☐ Tsis Muaj
	m) Tsav tsheb thauj mus ntsib tug kws kho mob los sis mus ntsib koj cov phooj ywg	☐ Muaj ☐ Tsis Muaj
	n) Ua tej hauj lwm hauv vaj hauv tsev los sis sab nraum lub tiaj nyom	☐ Muaj ☐ Tsis Muaj
	o) Coj mus saib tsev neeg los sis cov phooj ywg	☐ Muaj ☐ Tsis Muaj

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	p) Kev siv xov tooj	☐ Muaj ☐ Tsis Muaj
	q) Pab soj qab xyuas tej kev teem caij mus kuaj mob	☐ Muaj ☐ Tsis Muaj
33.	Yog teb tias xav tau rau ib nqi saum toj saud, koj puas xav txais tag nrho cov kev pab uas koj xav tau no?	☐ Muaj ☐ Tsis Muaj
34.	Koj puas muaj cov neeg hauv tsev neeg los sis lwm cov neeg txaus siab thiab tuaj yeem pab koj thaum koj xav tau nws?	☐ Muaj ☐ Tsis Muaj
35.	Koj puas xav tias koj tus neeg zov muaj sij hawm nyuaj los muab txhua yam kev pab uas koj xav tau?	☐ Xav ☐ Tsis Xav ☐ Kuv tsis muaj neeg zov.
36.	Puas muaj qee zaus uas koj tsis muaj nyiaj them tej khoom noj, nqis khiab tsev nyob, tej nqi dej thiab hluav taws xob, thiab nqi tshuaj?	☐ Xav Muaj ☐ Tsis Muaj
37.	Puas muaj ib tug neeg siv koj cov nyiaj uas koj tsis tau pom zoo?	☐ Muaj ☐ Tsis Muaj
38.	Ib daim foos hais tseg ua ntej yog ib hom lus qhia rau koj tus neeg hlub paub txog tej kev xaiv saib xyuas mob nkeeg uas koj xav tau yog muaj mob loj rau koj tus kheej. Koj puas muaj ib daim foos sau tseg txog kev tswj txoj sia los sis ib daim foos hais tseg ua ntej?	☐ Muaj ☐ Tsis Muaj
	a) Yog Muaj, nws sau txog dab tsi rau hauv hom ntawv no?	
	b) Yog Muaj, koj tus kws PCP/Tus Kws Kho Mob puas muaj ib	☐ Muaj ☐ Tsis Muaj

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	daim ntawv theej?	
	c) Yog Tsis Muaj, Puas xav kom kuv xa tej ntaub ntawv ntxiv tuaj rau koj?	☐ Xav ☐ Tsis Xav
39.	(Txhawm Rau Cov Nqe Lus Nug 39 txog 44, tsuas teb tau yog muaj hnub nyoog 13 xyoo los sis siab dua xwb) Hauv lub sij hawm peb lub hlis dhau los, koj puas xav tias koj yuav tsum txo los sis tso tseg kev haus dej haus cawv los sis siv tej tshuaj muaj yees?	☐ Xav ☐ Tsis Xav
40.	Hauv peb lub hlis dhau los, puas muaj ib tug neeg tau ze koj los sis ua rau koj npau taw uas hais kom koj txo los sis tso tseg kev haus dej haus cawv los sis siv tej tshuaj muaj yees?	☐ Xav ☐ Tsis Xav
41.	Hauv peb lub hlis dhau los, koj puas hnov tias koj yog neeg tsis zoo los sis neeg phem ntau npaum li cas txog qhov kev haus dej haus cawv los sis siv tej tshuaj muaj yees?	☐ Xav ☐ Tsis Xav
42.	Hauv peb lub hlis dhau los, koj puas tau sawv los es xav haus dej haus cawv los sis siv tej tshuaj muaj yees?	☐ Xav ☐ Tsis Xav
43.	Koj puas hnov zoo li tias muaj ib qho teeb meem los ntawm kev haus dej haus cawv los sis siv tej tshuaj muaj yees?	☐ Hnov Tau ☐ Tsis Hnov Tau
44,	Yog teb tias yog rau nqe lus 39-43, koj puas xav kom ib Tug Thawj Tswj Xyuas Teeb Meem hu xov tooj tuaj rau koj txhawm rau muab kev pab txhawb/kev qhuab qhia?	☐ Muaj ☐ Tsis Muaj
45.	Hauv 2 lub lwm tiam dhau los, koj muaj kev txaus siab los sis kev zoo siab ua tej hauj lwm no npaum li cas?	☐ Tsis muaj hlo li ☐ Muaj ntau hnub ☐ Ntau dua ib nrab ntawm cov hnub ☐ Yuav luag txhua hnub

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Daim Ntawv Ntsuam Xyuas kev Noj Qab Haus Huv

46.	Hauv lub sij hawm 2 lub lwm tiam dhau los, koj puas hnov tsis zoo, ntxhov siab los sis tag kev cia siab?	☐ Tsis muaj hlo li ☐ Muaj ntau hnub ☐ Ntau dua ib nrab ntawm cov hnub ☐ Yuav luag txhua hnub
47.	Ib lub hli dhau los (30 hnub), muaj puas tsawg hnub uas koj hnov kho siab zim?	☐ Tsis muaj li – Kuv yeej tsis hnov kho siab li ☐ Tsawg dua 5 hnub ☐ Ntau dua ib nrab ntawm cov hnub (ntau dua 15 hnub) ☐ Yuav luag txhua hnub – Kuv yeej hnov kho siab tas li
48.	Koj puas ntshai ib tug neeg los sis ntshai tsam ib tug neeg ua rau koj muaj mob?	☐ Ntshai ☐ Tsis Ntshai
	Ua tsaug uas koj siv lub sij hawm los sau daim ntawv tshawb fawb no tiav. Tej zaum yuav muaj ib tug neeg hu tuaj rau koj. Yog koj xav tau kev pab tshwj xeeb los muab kev saib xyuas rau koj li kev noj qab haus huv, peb tuaj yeem tham txog feem koj xav tau rau hauv "Pawg Kws Saib Xyuas Ntau Yam" los sis yam uas peb pheej hu tias kev ua tau raws li qhov "ICT". Peb yuav tsum suav txog cov tswv cuab ntawm koj pawg kws saib xyuas, piv txwv koj thawj tus kws kho mob, koj tus thawj tswj xyuas teeb meem, koj tus neeg zov, thiab koj tus kheej. Pawg kws ua hauj lwm no tuaj yeem los ntsib koj tim ntsej tim muag los sis hu xov tooj los sis ua hauj lwm ua ke rau txoj kev npaj kom tau raws li feem xav tau rau koj li kev noj qab haus huv. **Thov qhia tias koj twb tau nyeem thiab to taub tej hais los saum toj saud lawm: _____**	

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Առողջության հարցում

Անդամի անունը՝	**Անդամի տան հեռախոսահամարը՝**
	Անդամի բջջային հեռախոսահամարը՝
Այս հարցաշարը լրացնող անձը՝	**Անդամի առողջապահական խնամքի ID՝**
Այս հարցաշարը լրացնող անձի	**Անդամի ծննդյան ամսաթիվը՝** / /
հեռախոսահամարը՝	
	<u>Այսօրվա ամսաթիվը</u>: / /
Անդամի հետ կապը՝	

	ՀԱՐՑ	**ՊԱՏԱՍԽԱՆ**
1.	Ձեզ անգլերենից բացի այլ լեզու հարկավո՞ր է:	☐ Արաբերեն ☐ Կրեոլերեն ☐ Ֆրանսերեն ☐ Մանդարին ☐ Ռուսերեն ☐ Սոմալի ☐ Իսպաներեն ☐ Վիետնամերեն ☐ Ոչ մի ☐ Այլ լեզու
2.	Եթե այլ լեզու, խնդրում ենք նշել՝	
3.	Դուք որևէ նախապատվություն ունե՞ք, որի մասին մենք պետք է տեղեկանանք:	Նշեք բոլոր կիրառելիները՝ ☐ Մշակութային նախապատվություններ Մանրամասն նկարագրեք մշակութային նախապատվությունները՝ _____ ☐ Լսողության խանգարում Մանրամասն նկարագրեք լսողության խանգարման նախապատվությունները՝ _____ ☐ Գրագիտություն Մանրամասն նկարագրեք գրագիտության նախապատվությունները՝

		_____ ☐ Կրոն/Հոգևոր կարիքներ կամ նախապատվություններ Մանրամասն նկարագրեք կրոնական/հոգևոր որևէ կարիք կամ նախապատվություն՝ _____ ☐ Տեսողության խանգարում Մանրամասն նկարագրեք տեսողության խանգարման նախապատվությունները՝ _____ ☐ Այլ հատուկ նախապատվություններ Մանրամասն նկարագրեք որևէ հատուկ նախապատվություն՝ _____ ☐ Ոչ մի
4.	Ո՞րն է Ձեր **հիմնական** առողջական մտահոգությունն այս պահին:	
5.	Դուք հղի՞ եք:	☐ Այո ☐ Ոչ ☐ Կիրառելի չէ
6.	Դուք որևէ խնդիր ունե՞ք Ձեր թոքերի հետ կապված, ինչպես օրինակ՝ ասթմա, թոքերի քրոնիկ օբստրուկտիվ հիվանդություն կամ ցիստիկ ֆիբրոզ:	☐ Ասթմա ☐ Թոքերի քրոնիկ օբստրուկտիվ հիվանդություն (COPD) ☐ Ցիստիկ ֆիբրոզ ☐ Ոչ մի
7.	Դուք որևէ խնդիր ունե՞ք Ձեր սրտի կամ շրջանառության հետ կապված, ինչպես	☐ Նախասրտերի ֆիբրիլյացիա

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	օրինակ՝ նախասրտերի ֆիբրիլյացիա, սրտի իշեմիկ հիվանդություն, ծայրամասային զարկերակների հիվանդություն, սրտանոթային անբավարարություն կամ կաթված:	☐ Սրտի իշեմիկ հիվանդություն/Ծայրամասային զարկերակների հիվանդություն ☐ Սրտային անբավարարություն ☐ Ուղեղանոթային պատահար/Կաթված ☐ Բարձր ճնշում ☐ Ոչ մի
8.	Դուք որևէ խնդիր ունե՞ք երիկամների հետ կապված, ինչպես օրինակ՝ երիկամների քրոնիկ հիվանդություն կամ երիկամային հիվանդության վերջնային փուլ՝ դիալիզով:	☐ Երիկամների քրոնիկ հիվանդություն ☐ Երիկամային հիվանդության վերջնային փուլ՝ դիալիզով ☐ Ոչ մի
9.	Արդյո՞ք Ձեր բժիշկն ախտորոշել է Ձեզ մոտ վարքային խանգարում, ինչպես օրինակ՝ դեպրեսիա, շիզոֆրենիա կամ երկբևեռ խանգարում:	☐ Դեպրեսիա ☐ Շիզոֆրենիա ☐ Երկբևեռ ☐ Ոչ մի
10.	Ունե՞ք որևէ առողջական վիճակ, որ ազդում է Ձեր ուղեղի վրա, ինչպես օրինակ՝ նոպաներ, հիշողության խնդիրներ (թուլամտություն) կամ կաթված:	☐ Նոպաներ ☐ Ուղեղանոթային պատահար/Կաթված ☐ Թուլամտություն ☐ Ալցհայմերի հիվանդություն ☐ Ուղեղի այլ խնդիրներ՝ _____ ☐ Ոչ մի
11.	Դուք ցիռոզ ունե՞ք:	☐ Այո ☐ Ոչ
12.	Ունե՞ք մանգաղային բջիջների հիվանդություն:	☐ Այո ☐ Ոչ

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13.	Դուք ՄԻԱՎ կամ ՁԻԱՀ ունե՞ք:	☐ ՄԻԱՎ ☐ ՁԻԱՀ ☐ Ոչ մեկը
14.	Դուք ակտիվ քաղցկեղ ունե՞ք, որը բուժվում է քիմիոթերապիայով, ճառագայթմամբ կամ վիրահատությամբ:	☐ Այո ☐ Ոչ
15.	Դուք շաքարախտ (շաքար) ունե՞ք:	☐ Այո ☐ Ոչ
16.	Դուք ռևմատոիդ արթրիտ ունե՞ք	☐ Այո ☐ Ոչ
17.	Այլ առողջական խնդիրներ	☐ Այլ _____ _____ ☐ Ոչ մի
18.	Վերջին 6 ամսում Դուք շտապ օգնության բաժանմունք դիմե՞լ եք:	☐ Այո ☐ Ոչ
	ա) Եթե այո, քանի՞ անգամ եք շտապ օգնության բաժանմունք այցելել:	
	բ) Շտապ օգնության բաժանմունք այցելության նպատակը՝	
19.	Վերջին 6 ամսում Դուք գիշերն անցկացրե՞լ եք հիվանդանոցում:	☐ Այո ☐ Ոչ
	ա) Եթե այո, քանի՞ անգամ եք մնացել հիվանդանոցում:	
	բ) Եթե այո, հիվանդանոցում մնալու պատճառը՝	

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20.	Դուք հասկանու՞մ եք, թե ինչի համար են Ձեր դեղերը և ինչ նպատակով եք դրանք ընդունում:	☐ Այո ☐ Ոչ ☐ Ոչ մի դեղատոմսով դեղ ✓ Եթե ոչ, մենք խորհուրդ ենք տալիս՝ • Դնել Ձեր դեղերը "Թղթե տոպրակի" մեջ և վերցնել Ձեզ հետ հաջորդ բժշկի այցելությանը: ԿԱՄ • Զանգահարել մեր դեղագործին (855) 658-0918 հեռախոսահամարով, TTY՝ 711, երկուշաբթիից ուրբաթ, 8 a.m.-ից 5 p.m.-ը, ով կուսումնասիրի Ձեր դեղերը և կպատասխանի ցանկացած հարցի:
21.	Ձեզ օգնություն հարկավո՞ր է Ձեր դեղերի հետ կապված:	☐ Այո ☐ Ոչ
22.	Ձեզ օգնություն հարկավո՞ր է առողջապահական ձևաթղթերը լրացնելիս:	☐ Այո ☐ Ոչ
23.	Ձեզ օգնություն հարկավո՞ր է բժշկի այցելության ժամանակ հարցերին պատասխանելիս:	☐ Այո ☐ Ոչ
24.	Համեմատելով Ձեր տարիքի այլ անձանց հետո, Դուք կասեիք, որ Ձեր առողջությունը՝	☐ Գերազանց է ☐ Շատ լավ է ☐ Լավ է ☐ Բավարար է ☐ Վատ է
25.	Ձեզ մոտ որևէ փոփոխություն ի հայտ եկե՞լ է մտածողության, հիշողության կամ որոշումներ կայացնելու հետ կապված:	☐ Այո ☐ Ոչ
26.	Այս տարի գրիպի պատվաստում ստացե՞լ եք:	☐ Այո ☐ Ոչ

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27.	Ի՞նչ պայմաններում եք այս պահին ապրում:	☐ Անօթևան եմ ☐ Միայնակ եմ ապրում ☐ Ապրում եմ խմբային տանը ☐ Ապրում եմ ծերանոցում ☐ Ապրում եմ ժամանակավոր կացարանում ☐ Ապրում եմ աջակցման կենտրոնում ☐ Ապրում եմ ընտանիքի անդամների հետ ☐ Ապրում եմ ինձ հետ առնչություն չունեցող անձանց հետ ☐ Ապրում եք կնոջս/ամուսնուս հետ ☐ Ապրում եմ տանից դուրս վայրում ☐ Ապրում եմ այլ նահանգի բժշկական հաստատությունում ☐ Վերոնշյալներից ոչ մեկը ☐ Այլ
	ա) Եթե այլ, խնդրում ենք նկարագրել՝	
28.	Կարո՞ղ եք արդյոք անվտանգ ապրել և հեշտությամբ շարժվել տան մեջ:	☐ Այո ☐ Ոչ
29.	Եթե ոչ, արդյո՞ք Ձեր ապրած վայրն ունի՝	
	ա) Լավ լուսավորություն	☐ Այո ☐ Ոչ
	բ) Լավ ջեռուցում	☐ Այո ☐ Ոչ

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	գ) Լավ օդորակում	☐ Այո ☐ Ոչ
	դ) Բազրիք աստիճանների կամ թեքահարթակների վրա	☐ Այո ☐ Ոչ ☐ Չ/Ա – Աստիճաններ կամ թեքահարթակներ չկան
	ե) Տաք ջուր	☐ Այո ☐ Ոչ
	զ) Զուգարան տան մեջ	☐ Այո ☐ Ոչ
	է) Դրսի դռան փական	☐ Այո ☐ Ոչ
	ը) Դեպի տուն գնացող աստիճաններ կամ տան մեջի աստիճաններ	☐ Այո ☐ Ոչ
	թ) Վերելակ	☐ Այո ☐ Ոչ
	ժ) Անվասայլակն օգտագործելու տարածք	☐ Այո ☐ Ոչ ☐ Չ/Ա – Ինձ անվասայլակ հարկավոր չէ:
	ի) Ազատ ճանապարհ տնից դուրս գալու համար	☐ Այո ☐ Ոչ
30.	Անցյալ ամսվա ընթացքում Դուք վայր ընկե՞լ եք:	☐ Այո ☐ Ոչ
31.	Դուք վախենու՞մ եք վայր ընկնելուց:	☐ Այո ☐ Ոչ
32.	Ձեզ օգնություն հարկավո՞ր է ստորև նշված գործողությունների համար:	
	a) Լոգանք կամ ցնցուղ ընդունելը	☐ Այո ☐ Ոչ
	b) Աստիճաններով բարձրանալը	☐ Այո ☐ Ոչ
	c) Սնվելը	☐ Այո ☐ Ոչ

	d) Հագնվելը	☐ Այո ☐ Ոչ
	e) Ատամները խոզանակելը, մազերը սանրելը, սափրվելը	☐ Այո ☐ Ոչ
	f) Ուտելիք պատրաստելը կամ եփելը	☐ Այո ☐ Ոչ
	g) Անկողնուց կամ աթոռից վեր կենալը	☐ Այո ☐ Ոչ
	h) Առևտուր անելը կամ ուտելիք ստանալը	☐ Այո ☐ Ոչ
	i) Զուգարանից օգտվելը	☐ Այո ☐ Ոչ
	j) Քայլելը	☐ Այո ☐ Ոչ
	k) Ամանները կամ շորերը լվանալը	☐ Այո ☐ Ոչ
	l) Չեկեր դուրս գրելը կամ դրամի հաշվարկ պահելը	☐ Այո ☐ Ոչ
	m) Բժշկի գնալը կամ ընկերներին այցելելը	☐ Այո ☐ Ոչ
	n) Տնային կամ այգու գործեր անելը	☐ Այո ☐ Ոչ
	o) Ընտանիքի անդամներին կամ ընկերներին այցելելը	☐ Այո ☐ Ոչ
	p) Հեռախոսից օգտվելը	☐ Այո ☐ Ոչ
	q) Ժամադրություններին հետևելը	☐ Այո ☐ Ոչ
33.	Եթե այո եք պատասխանում վերոնշյալներից որևէ մեկին, ստանում եք արդյո՞ք այդ գործողությունների հետ կապված ամբողջ անհրաժեշտ օգնությունը:	☐ Այո ☐ Ոչ

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34.	Դուք ընտանիքի անդամներ կամ այլ անձինք ունե՞ք, ովքեր ցանկություն ունեն և կարող են օգնել անհրաժեշտության դեպքում:	☐ Այո ☐ Ոչ
35.	Դուք երբևիցե մտածում եք, որ Ձեր խնամողը դժվարանում է տրամադրել Ձեզ անհրաժեշտ ամբողջ օգնությունը:	☐ Այո ☐ Ոչ ☐ Ես խնամող չունեմ:
36.	Երբևիցե Ձեր դրամը վերջանու՞մ է ուտելիքի, տան վարձի, հաշիվների և դեղերի համար վճարելու համար:	☐ Այո ☐ Ոչ
37.	Որևէ մեկն օգտագործու՞մ է Ձեր դրամն առանց Ձեր թույլտվության:	☐ Այո ☐ Ոչ
38.	Նախնական հրահանգը փաստաթուղթ է, որը Ձեր հարազատներին թույլ է տալիս իմանալ առողջապահական խնամքի Ձեր ընտրություններն, եթե Դուք չափից ավելի հիվանդ եք ինքներդ որոշում կայացնելու համար: Դուք կտակ կամ նախնական հրահանգ ունե՞ք:	☐ Այո ☐ Ոչ
	ա) Եթե Այո, ի՞նչ տեսակի փաստաթուղթ է դա:	
	բ) Եթե Այո, արդյո՞ք Ձեր PCP/Բժիշկն ունի դրա պատճենը:	☐ Այո ☐ Ոչ
	գ) Եթե Ոչ, կարո՞ղ եմ արդյոք ուղարկել Ձեզ հավելյալ տեղեկություններ	☐ Այո ☐ Ոչ

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39.	(Հարցեր 39-ից մինչև 44, պատասխանեք միայն, եթե 13 և ավելի տարեկան եք) Վերջին երեք ամսվա ընթացքում, զգացե՞լ եք արդյոք, որ պետք է կրճատեք կամ դադարեք խմելը կամ թմրադեղեր օգտագործելը:	☐ Այո ☐ Ոչ
40.	Վերջին երեք ամսվա ընթացքում, որևէ մեկը զայրացրել կամ նյարդայնացրել է Ձեզ՝ ասելով, որ Դուք պետք է կրճատեք կամ դադարեցնեք խմելը կամ թմրադեղեր օգտագործելը:	☐ Այո ☐ Ոչ
41.	Վերջին երեք ամսվա ընթացքում, մեղավոր կամ վատ զգացե՞լ եք խմելու կամ թմրադեղեր օգտագործելու պատճառով:	☐ Այո ☐ Ոչ
42.	Վերջին երեք ամսվա ընթացքում, եղե՞լ է ժամանակ, որ արթնացել եք՝ ցանկանալով ոգելից խմիչք խմել կամ թմրադեղ օգտագործել:	☐ Այո ☐ Ոչ
43.	Դուք զգու՞մ եք, որ թմրադեղերի կամ ալկոհոլի հետ կապված խնդիրներ ունեք:	☐ Այո ☐ Ոչ
44.	Եթե այո եք պատասխանում 39-43 հարցերին, ցանկանու՞մ եք արդյոք, որ Ձեր Գործի կառավարիչը զանգահարի Ձեզ՝ աջակցություն/ուսուցում տրամադրելու համար:	☐ Այո ☐ Ոչ
45.	Վերջին 2 շաբաթվա ընթացքում, որքա՞ն հաճախ եք հետաքրքրության կամ հաճույքի պակաս զգացել որևէ բան անելուց:	☐ Երբեք ☐ Մի քանի անգամ ☐ Օրերի կեսից ավելին ☐ Գրեթե ամեն օր
46.	Վերջին 2 շաբաթվա ընթացքում որքա՞ն հաճախ եք Ձեզ անտրամադիր, ընկճված կամ անհույս զգացել:	☐ Երբեք ☐ Մի քանի անգամ ☐ Օրերի կեսից ավելին ☐ Գրեթե ամեն օր

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47.	Վերջին ամսվա ընթացքում (30 օր), քանի՞ օր եք միայնակ զգացել:	☐ Ոչ մի – Ես երբեք միայնակ չեմ զգում ☐ 5 օրից պակաս ☐ Օրվա կեսերից ավելին (ավելի քան 15 օր) ☐ Օրերի մեծ մասը – Ես միշտ միայնակ եմ զգում
48.	Դուք վախենու՞մ եք որևէ մեկից կամ որևէ մեկը Ձեզ վնասու՞մ է:	☐ Այո ☐ Ոչ
	Շնորհակալություն, որ ժամանակ տրամադրեցիք հարցաշարը լրացնելու համար: Որևէ մեկը թերևս կկապվի Ձեզ հետ: Եթե Ձեզ լրացուցիչ օգնություն է հարկավոր Ձեր առողջության մասին հոգալու համար, մենք կարող եք քննարկել Ձեր կարիքները “Միջդիսցիպլինար խնամքի թիմի”, կամ, ինչպես մենք այն անվանում ենք՝ “ICT” հանդիպման ժամանակ: Մենք կներառենք Ձեր խնամքի թիմի անդամներին, օրինակ՝ Ձեր առաջնային խնամքի բժշկին, Ձեր գործի կառավարչին, Ձեր խնամողին և Ձեզ: Այս թիմը կարող է հանդիպել անձամբ կամ հեռախոսով և միասին աշխատել՝ Ձեր առողջապահական կարիքները բավարարող ծրագիր մշակելու համար: **Խնդրում ենք դնել Ձեր անվան սկզբնատառերը՝ հաստատելով, որ կարդացել և հասկացել եք վերոնշյալը՝** _____

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ឈ្មោះរបស់សមាជិក៖	**លេខទូរសព្ទនៅផ្ទះរបស់សមាជិក៖**
	លេខទូរសព្ទដៃរបស់សមាជិក៖
អ្នកបំពេញការស្ទង់មតិនេះ៖	**ប័ណ្ណថែទាំសុខភាពរបស់សមាជិក៖**
ទូរសព្ទរបស់អ្នកបំពេញការស្ទង់មតិនេះ៖	**ថ្ងៃខែឆ្នាំកំណើតរបស់សមាជិក៖**
ទំនាក់ទំនងជាមួយសមាជិក៖	**កាលបរិច្ឆេទថ្ងៃនេះ៖** / /

	សំណួរ	ការឆ្លើយតប
1.	តើអ្នកត្រូវការភាសាដទៃក្រៅពីភាសាអង់គ្លេសដែរឬទេ?	☐ ភាសាអារ៉ាប់ ☐ ភាសាក្រអូល ☐ ភាសាបារាំង ☐ ភាសាចិនកុកង៉ី ☐ ភាសារុស្ស៊ី ☐ ភាសាសុម៉ាលី ☐ ភាសាអេស្ប៉ាញ ☐ ភាសាវៀតណាម ☐ មិនត្រូវការ ☐ ភាសាដទៃទៀត
2.	ប្រសិនបើភាសាដទៃទៀត សូមបញ្ជាក់៖	
3.	តើអ្នកមានតម្រូវការពិសេសដទៃទៀតដែលពួកយើងត្រូវដឹងដែរឬទេ?	សូមជ្រើសធីសជម្រើសដែលត្រូវនឹងអ្នកទាំងអស់៖ ☐ ចំណូលចិត្តលើវប្បធម៌ណាមួយ ការបន្ថែមចំណូលចិត្តលើវប្បធម៌ណាមួយ _____ ☐ ភាពអន់ថយនៃការស្តាប់ ការបន្ថែមនូវភាពអន់ថយនៃការស្តាប់ ចំណូលចិត្ត៖ _____ ☐ អក្ខរកម្ម ការបន្ថែមនូវចំណូលចិត្តអក្ខរកម្ម៖ _____

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		☐ តម្រូវការ ឬចំណូលចិត្តនៃសាសនា/ផ្លូវចិត្ត ការបន្ថែមលើតម្រូវការនៃសាសនា/ផ្លូវចិត្ត ចំណូលចិត្ត៖ _____ ☐ ភាពអន់ថយនៃការមើលឃើញ ការបន្ថែមលើភាពអន់ថយនៃការមើលឃើញ ចំណូលចិត្ត៖ _____ ☐ ចំណូលចិត្តពិសេសដទៃទៀត ការបន្ថែមលើចំណូលចិត្តពិសេសដទៃទៀត _____ ☐ គ្មាន
4.	តើអ្វីទៅជា**បញ្ហា**សុខភាពចំបងរបស់អ្នកនៅពេលបច្ចុប្បន្ន?	
5.	តើអ្នកកំពុងមានផ្ទៃពោះមែនឬទេ?	☐ មែន ☐ ទេ ☐ មិនពាក់ព័ន្ធ
6.	តើអ្នកមានបញ្ហាសួត ដូចជាជំងឺហឺត ជំងឺស្ទះផ្លូវដង្ហើមរ៉ាំរ៉ៃ ឬក្រិនសួតដែរឬទេ?	☐ ជំងឺហឺត ☐ ជំងឺស្ទះផ្លូវដង្ហើមរ៉ាំរ៉ៃ (COPD) ☐ ក្រិនសួត ☐ គ្មាន
7.	តើអ្នកមានបញ្ហាជាមួយបេះដូងអ្នក ឬចរន្តឈាម ដូចជាជំងឺកន្ត្រាក់សាច់ដុំបេះដូង ជំងឺសរសៃឈាមបេះដូង ជំងឺស្ទះសរសៃឈាម ជំងឺខ្សោយបេះដូង ឬជំងឺដាច់សរសៃឈាមក្នុងខួរក្បាលដែរឬទេ?	☐ ជំងឺកន្ត្រាក់សាច់ដុំបេះដូង ☐ សរសៃឈាមបេះដូង/ស្ទះសរសៃឈាម ជំងឺ

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		☐ ជំងឺខ្សោយបេះដូង ☐ ជំងឺដាច់សរសៃឈាមក្នុងខួរក្បាល ☐ ជំងឺលើសឈាម ☐ គ្មាន
8.	តើអ្នកមានបញ្ហាតម្រងនោម ដូចជាជំងឺតម្រងនោមរ៉ាំរ៉ៃ ឬជំងឺតម្រងនោមដំណាក់កាលចុងក្រោយដោយការលាងឈាមដែរឬទេ?	☐ ជំងឺតម្រងនោមរ៉ាំរ៉ៃ ☐ ជំងឺតម្រងនោមដំណាក់កាលចុងក្រោយដោយការលាងឈាម ☐ គ្មាន
9.	តើគ្រូពេទ្យរបស់អ្នកបានធ្វើរោគវិនិច្ឆ័យថាអ្នកមានស្ថានភាពអាកប្បកិរិយានៃសុខភាពដូចជាជំងឺធ្លាក់ទឹកចិត្ត ជំងឺវិកលចរិត ឬជំងឺបាយប៉ូឡាដែរឬទេ?	☐ ជំងឺធ្លាក់ទឹកចិត្ត ☐ ជំងឺវិកលចរិត ☐ ជំងឺបាយប៉ូឡា ☐ គ្មាន
10.	តើអ្នកមានលក្ខខណ្ឌណាមួយដែលអាចប៉ះពាល់ដល់ខួរក្បាលរបស់អ្នកដូចជា រោគប្រកាច់ ការចងចាំ(ជំងឺវង្វេងវង្វាន់) ឬជំងឺដាច់សរសៃឈាមក្នុងខួរក្បាលដែរឬទេ?	☐ រោគប្រកាច់ ☐ គ្រោះថ្នាក់សរសៃឈាមខួរក្បាល/ជំងឺដាច់សរសៃឈាមក្នុងខួរក្បាល ☐ ជំងឺវង្វេងវង្វាន់ ☐ ជំងឺភ្លេចភ្លាំង ☐ ស្ថានភាពខួរក្បាលដទៃទៀត៖ ____________________ ☐ គ្មាន
11.	តើអ្នកមានរោគក្រិនថ្លើមដែរឬទេ?	☐ បាទ/ចាស ☐ ទេ
12.	តើអ្នកមានជំងឺកោសិកាឈាមក្រហមដែរឬទេ?	☐ បាទ/ចាស ☐ ទេ
13.	តើអ្នកមានជំងឺ HIV ឬអេដស៍ដែរឬទេ?	☐ HIV ☐ អេដស៍ ☐ គ្មានទាំងពីរ

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14.	តើអ្នកមានជំងឺមហារីកដែលកំពុងព្យាបាលដោយសារធាតុគីមី វិទ្យុសកម្ម ឬការវះកាត់ឬទេ?	☐ បាទ/ចាស ☐ ទេ
15.	តើអ្នកមានជំងឺទឹកនោមផ្អែម(ជាតិស្ករ)ឬទេ?	☐ បាទ/ចាស ☐ ទេ
16.	តើអ្នកមានរោគរលាកសន្លាក់ឆ្អឹងឬទេ?	☐ បាទ/ចាស ☐ ទេ
17.	លក្ខខណ្ឌដទៃទៀត	☐ ផ្សេងៗ _____ _____ ☐ គ្មាន
18.	តើអ្នកបានចូលទៅបន្ទប់សង្គ្រោះបន្ទាន់ក្នុងរំឡុងពេល 6 ខែចុងក្រោយនេះឬទេ?	☐ បាទ/ចាស ☐ ទេ
	a) បើមាន តើអ្នកបានចូលចំនួនប៉ុន្មានដង?	
	b) ហេតុផលដែលអ្នកចូលបន្ទប់សង្គ្រោះបន្ទាន់៖	
19.	តើអ្នកបានសម្រាកនៅក្នុងមន្ទីរពេទ្យមួយយប់នៅក្នុងរំឡុងពេល 6 ខែចុងក្រោយនេះទេ?	☐ បាទ/ចាស ☐ ទេ
	a) បើមាន តើអ្នកស្នាក់នៅមន្ទីរពេទ្យប៉ុន្មានដែរ?	
	b) បើមាន សូមបញ្ជាក់អំពីហេតុផលដែលអ្នកស្នាក់នៅមន្ទីរពេទ្យ៖	

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20.	តើអ្នកដឹងថាថ្នាំរបស់អ្នកគឺសម្រាប់ជំងឺអ្វី និងមូលហេតុដែលអ្នកត្រូវផឹកវាដែរឬទេ?	☐ បាទ/ចាស ☐ ទេ ☐ គ្មានថ្នាំដែលត្រូវបានចេញវេជ្ជបញ្ជាទេ ✓ បើគ្មាន យើងសូមណែនាំ៖ • សូមដាក់ថ្នាំរបស់អ្នកក្នុង "កញ្ចប់ពណ៌ត្នោត" រួចយកវាទៅតាមអ្នក ពេលអ្នកណាត់ជួបពេទ្យរបស់អ្នកនៅពេលក្រោយ។ ឬ • ទូរសព្ទទៅកាន់ឱសថការីរបស់យើងខ្ញុំតាមរយៈលេខ (855) 658-0918, TTY: 711, ពីថ្ងៃចន្ទដល់សុក្រ ពីម៉ោង 8 ព្រឹក រហូតដល់ម៉ោង 5 ល្ងាច ដែលពួកគាត់នឹងធ្វើការពិនិត្យឡើងវិញនូវថ្នាំរបស់អ្នក និងឆ្លើយសំនួររបស់អ្នក។
21.	តើអ្នកត្រូវការជំនួយក្នុងការផឹកថ្នាំរបស់អ្នកឬទេ?	☐ បាទ/ចាស ☐ ទេ
22.	តើអ្នកត្រូវការជំនួយក្នុងការបំពេញទម្រង់បែបបទសុខភាពឬទេ?	☐ បាទ/ចាស ☐ ទេ
23.	តើអ្នកត្រូវការជំនួយក្នុងការឆ្លើយសំនួរក្នុងអំឡុងពេលដែលអ្នកទៅជួបគ្រូពេទ្យដែរឬទេ?	☐ បាទ/ចាស ☐ ទេ
24.	បើប្រៀបធៀបទៅនឹងអ្នកដែលមានអាយុស្របាលអ្នក តើអ្នកគិតថាសុខភាពរបស់អ្នកស្ថិតក្នុងកម្រិតណាដែរ៖	☐ ល្អឥតខ្ចោះ ☐ ល្អណាស់ ☐ ល្អ ☐ បង្គួរ ☐ អន់
25.	តើអ្នកមានការផ្លាស់ប្តូរការគិត ការចងចាំ ឬការសម្រេចចិត្តណាមួយឬទេ?	☐ បាទ/ចាស ☐ ទេ
26.	តើអ្នកបានទទួលបានការចាក់ថ្នាំបង្ការជំងឺផ្តាសាយធំនៅក្នុងឆ្នាំនេះឬទេ?	☐ បាទ/ចាស ☐ ទេ
27.	តើស្ថានភាពរស់នៅរបស់អ្នកក្នុងពេលបច្ចុប្បន្នយ៉ាងណាដែរ?	☐ គ្មានទីជម្រក ☐ រស់នៅម្នាក់ឯង

		☐ រស់នៅក្នុងផ្ទះរួមគ្នា ☐ រស់នៅមណ្ឌលចាស់ជរា ☐ រស់នៅដោយមានទីជម្រក ☐ រស់នៅក្នុងមណ្ឌលផ្តល់ជំនួយសម្រាប់ការរស់នៅ ☐ រស់នៅជាមួយគ្រួសារឯទៀត ☐ រស់នៅជាមួយអ្នកមិនជាប់សាច់ឈាម ☐ រស់នៅជាមួយប្តី/ប្រពន្ធ ☐ រស់នៅកន្លែងក្រៅពីផ្ទះ ☐ រស់នៅក្រៅពីមណ្ឌលវេជ្ជសាស្ត្ររបស់រដ្ឋ ☐ គ្មានក្នុងជម្រើសខាងលើ ☐ ផ្សេងទៀត
	a) ប្រសិនបើមានផ្សេងទៀត សូមបញ្ជាក់៖	
28.	តើអ្នកអាចរស់នៅ និងធ្វើដំណើរដោយសុវត្ថិភាពនៅជុំវិញផ្ទះអ្នកឬទេ?	☐ បាទ/ចាស ☐ ទេ
29.	ប្រសិនបើមិនអាច តើកន្លែងដែលអ្នករស់នៅមាន៖	
	a) ពន្ធឺល្អ	☐ បាទ/ចាស ☐ ទេ
	b) កម្តៅគ្រប់គ្រាន់	☐ បាទ/ចាស ☐ ទេ
	c) ត្រជាក់គ្រប់គ្រាន់	☐ បាទ/ចាស ☐ ទេ
	d) មានបង្គាន់ដៃនៅតាមជណ្តើរ ឬផ្លូវឡើងជណ្តើរ	☐ បាទ/ចាស ☐ ទេ ☐ គ្មាន — គ្មានជណ្តើរ ឬផ្លូវឡើងជណ្តើរឡើយ

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	e) ទឹកក្តៅ	☐ បាទ/ចាស ☐ ទេ
	f) បន្ទប់ទឹកនៅក្នុងផ្ទះ	☐ បាទ/ចាស ☐ ទេ
	g) ទ្វារទៅសោរខាងក្រៅ	☐ បាទ/ចាស ☐ ទេ
	h) ជណ្តើរទៅក្នុងផ្ទះ ឬជណ្តើរ នៅក្នុងផ្ទះ	☐ បាទ/ចាស ☐ ទេ
	i) ជណ្តើរយន្ត	☐ បាទ/ចាស ☐ ទេ
	j) ទីធ្លាសម្រាប់ប្រើកៅអីរុញ	☐ បាទ/ចាស ☐ ទេ ☐ គ្មាន - ខ្ញុំមិនត្រូវការកៅអីរុញទេ។
	k) ផ្លូវចេញពីផ្ទះស្រឡះ	☐ បាទ/ចាស ☐ ទេ
30.	តើអ្នកមានដួលនៅក្នុងរយៈពេលមួយខែចុងក្រោយនេះឬទេ?	☐ បាទ/ចាស ☐ ទេ
31.	តើអ្នកខ្លាចការដួលឬទេ?	☐ បាទ/ចាស ☐ ទេ
32.	តើអ្នកត្រូវការជំនួយជាមួយសកម្មភាពដែលបង្ហាញខាងក្រោមនេះឬទេ?	
	a) ងូតទឹក ឬងូតទឹកផ្កាឈូក	☐ បាទ/ចាស ☐ ទេ
	b) ដើរឡើងជណ្តើរ	☐ បាទ/ចាស ☐ ទេ
	c) ទទួលទានអាហារ	☐ បាទ/ចាស ☐ ទេ
	d) ផ្លាស់សម្លៀកបំពាក់	☐ បាទ/ចាស ☐ ទេ
	e) ដុះធ្មេញ សិតសក់ កោរមាម	☐ បាទ/ចាស ☐ ទេ
	f) ចម្អិនអាហារ ឬរើម្ហូប	☐ បាទ/ចាស ☐ ទេ

	g) ដើរចេញពីត្រែ ឬកៅអី	☐ បាទ/ចាស ☐ ទេ
	h) ទិញទំនិញ ឬទិញអាហារ	☐ បាទ/ចាស ☐ ទេ
	i) ប្រើប្រាស់បង្គន់	☐ បាទ/ចាស ☐ ទេ
	j) ដើរ	☐ បាទ/ចាស ☐ ទេ
	k) លាងចាន ឬបោកខោអាវ	☐ បាទ/ចាស ☐ ទេ
	l) សសេរសែក ឬតាមដានទឹកប្រាក់	☐ បាទ/ចាស ☐ ទេ
	m) ស្វែងរកយានជំនិះទៅជួបគ្រូពេទ្យ ឬទៅជួបមិត្តភក្តិ	☐ បាទ/ចាស ☐ ទេ
	n) ធ្វើការងារផ្ទះ ឬនៅទីធ្លា	☐ បាទ/ចាស ☐ ទេ
	o) ចេញក្រៅទៅលេងគ្រួសារ ឬមិត្តភក្តិ	☐ បាទ/ចាស ☐ ទេ
	p) ប្រើប្រាស់ទូរសព្ទ	☐ បាទ/ចាស ☐ ទេ
	q) តាមដានការណាត់ជួប	☐ បាទ/ចាស ☐ ទេ
33.	ប្រសិនបើជម្រើសខាងលើត្រូវនឹងអ្នក តើអ្នកកំពុងទទួលបានជំនួយដែលអ្នកត្រូវការទាំងអស់ជាមួយនឹងសកម្មភាពទាំងនេះឬទេ?	☐ បាទ/ចាស ☐ ទេ
34.	តើអ្នកមានសមាជិកគ្រួសារ ឬអ្នកណាផ្សេងដែលនឹងអាចជួយអ្នកនៅពេលដែលអ្នកត្រូវការឬទេ?	☐ បាទ/ចាស ☐ ទេ
35.	តើអ្នកធ្លាប់គិតថា អ្នកថែទាំអ្នក មានការលំបាកក្នុងការផ្តល់ជំនួយដែលអ្នកត្រូវការទាំងអស់ទៅដល់អ្នកឬទេ?	☐ បាទ/ចាស ☐ ទេ ☐ ខ្ញុំគ្មានអ្នកថែទាំទេ។
36.	តើពេលខ្លះអ្នកធ្លាប់គ្មានលុយសម្រាប់ទិញអាហារ បង់ថ្លៃផ្ទះ បង់ថ្លៃសេវាផ្សេងៗ និងបង់ថ្លៃថ្នាំពេទ្យឬទេ?	☐ បាទ/ចាស ☐ ទេ

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37.	តើមានអ្នកណាដែលកំពុងប្រើប្រាស់លុយរបស់អ្នក ដោយគ្មានការយល់ព្រមពីអ្នកឬទេ?	☐ បាទ/ចាស ☐ ទេ
38.	ការណែនាំជាមុន គឺជាទំរង់មួយដែលអាចឲ្យអ្នកដែលអ្នកស្រលាញ់ដឹងពីជម្រើសថែទាំសុខភាពរបស់អ្នក ប្រសិនបើអ្នកឈឺធ្ងន់និងមិនអាចសម្រេចចិត្តដោយខ្លួនឯងបាន។ តើអ្នកមានពាក្យបណ្តឹង ឬការណែនាំជាមុនដែលត្រៀមរួចជាស្រេចឬទេ?	☐ បាទ/ចាស ☐ ទេ
	បើមាន តើវាជាឯកសារប្រភេទណា?	
	បើមាន តើPCP/គ្រូពេទ្យរបស់អ្នកមានសេចក្តីចម្លងដែរឬទេ?	☐ បាទ/ចាស ☐ ទេ
	បើគ្មាន តើខ្ញុំអាចផ្តល់ព័ត៌មានបន្ថែមដល់អ្នកបានដែរឬទេ?	☐ បាទ/ចាស ☐ ទេ
39.	(សម្រាប់សំនួរទី 39ដល់44 សូមផ្តល់ចម្លើយ ប្រសិនបើអ្នកមានអាយុ 13ឆ្នាំ ឬច្រើនជាងនេះ) ក្នុងរយៈពេលបីខែចុងក្រោយនេះ តើអ្នកមានអារម្មណ៍ថា អ្នកបានកាត់បន្ថយ ឬឈប់ផឹកស្រា ឬប្រើប្រាស់ថ្នាំឬទេ?	☐ បាទ/ចាស ☐ ទេ
40.	ក្នុងរយៈពេលបីខែចុងក្រោយនេះ តើមានអ្នកណារំខានអ្នកដោយប្រាប់ឲ្យអ្នកកាត់បន្ថយ ឬបញ្ឈប់ការផឹកស្រា ឬប្រើប្រាស់ថ្នាំឬទេ?	☐ បាទ/ចាស ☐ ទេ
41.	ក្នុងរយៈពេលបីខែចុងក្រោយនេះ តើអ្នកមានអារម្មណ៍ខុសឆ្គង ឬមិនល្អអំពីចំនួនស្រាដែលអ្នកបានផឹក ឬថ្នាំដែលអ្នកបានប្រើប្រាស់ឬទេ?	☐ បាទ/ចាស ☐ ទេ
42.	ក្នុងរយៈពេលបីខែចុងក្រោយនេះ តើអ្នកមានទំនោរចង់ផឹកស្រា ឬប្រើប្រាស់ថ្នាំពេលដែលអ្នកងើបពីគេងឬទេ?	☐ បាទ/ចាស ☐ ទេ

43.	តើអ្នកមានអារម្មណ៍ថា អ្នកមានបញ្ហាជាមួយថ្នាំ ឬស្រាឬទេ?	☐ បាទ/ចាស ☐ ទេ
44.	បើសិនជាចម្លើយរបស់អ្នកគឺបាទ/ចាសពីសំនួរ 39-43 តើអ្នកចង់ឲ្យអ្នកគ្រប់គ្រងករណីនេះ ទូរសព្ទទៅអ្នកដើម្បីផ្តល់ជំនួយ/ចំណេះដឹងឬទេ?	☐ បាទ/ចាស ☐ ទេ
45.	តើរយៈពេល2សប្តាហ៍នេះ តើអ្នកមានចំណាប់អារម្មណ៍ ឬភាពរីករាយតិចតួចក្នុងការធ្វើអ្វីមួយឬទេ?	☐ គ្មានទាល់តែសោះ ☐ មានពីរបីថ្ងៃដែរ ☐ ជាងពាក់កណ្តាលថ្ងៃ ☐ ស្ទើរតែរាល់ថ្ងៃ
46.	តើរយៈពេល2សប្តាហ៍នេះ តើអ្នកមានអារម្មណ៍អន់ចិត្ត ធ្លាក់ទឹកចិត្ត ឬអស់សង្ឃឹមជារឿយៗប៉ុណ្ណា?	☐ គ្មានទាល់តែសោះ ☐ មានពីរបីថ្ងៃដែរ ☐ ជាងពាក់កណ្តាលថ្ងៃ ☐ ស្ទើរតែរាល់ថ្ងៃ
47.	ក្នុងរយៈពេលមួយខែចុងក្រោយ (30ថ្ងៃ)នេះ តើមានប៉ុន្មានថ្ងៃដែលអ្នកមានអារម្មណ៍ថាឯកា?	☐ ទេ - ខ្ញុំមិនដែលមានអារម្មណ៍ថាឯកាទេ ☐ តិចជាង5ថ្ងៃ ☐ ជាងពាក់កណ្តាលថ្ងៃ (លើស15ថ្ងៃ) ☐ ជាញឹកញាប់ - ខ្ញុំតែងតែមានអារម្មណ៍ថាឯកា
48.	តើអ្នកខ្លាចនរណាម្នាក់ ឬខ្លាចនរណាម្នាក់ធ្វើបាបអ្នកឬទេ?	☐ បាទ/ចាស ☐ ទេ

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	សូមអរគុណក្នុងការចំណាយពេលវេលាក្នុងការបំពេញការស្ទង់មតិនេះ។ ឧរណាម្នាក់នឹងធ្វើការទាក់ទងទៅអ្នក។ ប្រសិនបើអ្នកត្រូវការជំនួយបន្ថែមក្នុងការថែទាំសុខភាពអ្នក ពួកយើងអាចពិភាក្សាពីតម្រូវការរបស់អ្នកក្នុង "ក្រុមថែទាំដោយអ្នកជំនាញ" ឬក៏យើងហៅថា ការប្រជុំ "ICT"។ ពួកយើងនឹងដាក់បញ្ចូលសមាជិកក្នុងក្រុមថែទាំរបស់អ្នក ដូចជាគ្រូពេទ្យបឋមរបស់អ្នក អ្នកគ្រប់គ្រងករណីរបស់អ្នក អ្នកថែទាំអ្នក និងអ្នកផ្តាល់ផងដែរ។ ក្រុមនេះអាចទៅជួបដោយផ្ទាល់ ឬតាមរយៈទូរសព្ទ និងធ្វើការរួមគ្នាដើម្បីរៀបចំគម្រោងមួយដើម្បីបំពេញតម្រូវការការថែទាំសុខភាពរបស់អ្នក។ **សូមចុះហត្ថលេខាដើម្បីបញ្ជាក់ថាអ្នកបានអាន និងយល់អំពីសេចក្តីខាងលើ៖** _____

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Pangalan ng Miyembro: **Taong Kukumpleto sa Survey na ito:** **Numero ng Telepono para sa Taong Kukumpleto sa Survey na ito:** **Ugnayan sa Miyembro:**	**Numero ng Telepono sa Bahay ng Miyembro:** **Numero ng Cell Phone ng Miyembro:** **Healthcare ID ng Miyembro:** **Petsa ng Kapanganakan ng Miyembro:** **<u>Petsa Ngayong Araw</u>:** / /

	TANONG	**SAGOT**
1.	Mayroon ka bang pangangailangan sa wikang bukod pa sa English?	☐ Arabic ☐ Creole ☐ French ☐ Mandarin ☐ Russian ☐ Somali ☐ Spanish ☐ Vietnamese ☐ Wala ☐ Iba Pang Wika
2.	Kung Iba Pang Wika, pakisaad:	
3.	Mayroon ka bang anumang espesyal na kagustuhang dapat naming malaman?	Lagyan ng tsek ang lahat ng nalalapat: ☐ Mga Kultural na Kagustuhan Isaad ang anumang kultural na kagustuhan: _____ ☐ Problema sa Pandinig Isaad ang anumang kagustuhan kaugnay ng problema sa pandinig: _____ ☐ Kakayahan sa Pagbasa at Pagsulat Isaad ang anumang kagustuhan kaugnay ng kakayahan sa pagbasa at pagsulat:

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		_____ ☐ Mga Kagustuhan o Pangangailangang Panrelihiyon/Pang-espiritwal Isaad ang anumang pangangailangan o kagustuhang Panrelihiyon o Pang-espiritwal: _____ ☐ Problema sa Paningin Isaad ang anumang kagustuhan kaugnay ng problema sa paningin: _____ ☐ Iba Pang Espesyal na Kagustuhan Isaad ang anumang espesyal na kagustuhan: _____ ☐ Wala
4.	Ano ang iyong **pangunahing** alalahanin tungkol sa kalusugan sa ngayon?	
5.	Buntis ka ba?	☐ Oo ☐ Hindi ☐ Hindi Naaangkop
6.	Mayroon ka bang anumang problema sa iyong baga, tulad ng hika, chronic obstructive pulmonary disease, o cystic fibrosis?	☐ Hika ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Cystic Fibrosis ☐ Wala
7.	Mayroon ka bang anumang problema sa iyong puso o sa pagdaloy ng iyong dugo tulad ng atrial fibrillation, coronary artery disease,	☐ Atrial Fibrillation ☐ Coronary Artery Disease/ Peripheral Arterial

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	peripheral arterial disease, congestive heart failure, o stroke?	Disease ☐ Congestive Heart Failure ☐ Cerebral Vascular Accident/Stroke ☐ Hypertension ☐ Wala
8.	Mayroon ka bang anumang problema sa iyong mga kidney tulad ng chronic kidney disease o end stage renal disease na naka-dialysis?	☐ Chronic Kidney Disease ☐ End Stage Renal Disease na Naka-dialysis ☐ Wala
9.	Na-diagnose ka ba ng iyong doktor na mayroon kang kundisyon sa kalusugan ng pag-uugali gaya ng depresyon, schizophrenia, o bipolar disorder?	☐ Depresyon ☐ Schizophrenia ☐ Bipolar ☐ Wala
10.	Mayroon ka bang anumang kundisyong nakakaapekto sa iyong utak tulad ng mga seizure, memorya (dementia), o stroke?	☐ Mga Seizure ☐ Cerebral Vascular Accident/Stroke ☐ Dementia ☐ Alzheimer's Disease ☐ Iba pang kundisyon sa utak: _____ ☐ Wala
11.	Mayroon ka bang cirrhosis?	☐ Mayroon ☐ Wala
12.	Mayroon ka bang sickle cell?	☐ Mayroon ☐ Wala
13.	Mayroon ka bang HIV o AIDS?	☐ HIV ☐ AIDS ☐ Wala ng alinman sa mga ito

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14.	Mayroon ka bang aktibong kanser na ginagamot sa pamamagitan ng chemo, radiation, o operasyon?	☐ Mayroon ☐ Wala
15.	Mayroon ka bang diyabetis (mga asukal)?	☐ Mayroon ☐ Wala
16.	Mayroon ka bang rheumatoid arthritis?	☐ Mayroon ☐ Wala
17.	Iba pang kundisyon	☐ Iba Pa_____ _____ ☐ Wala
18.	Nagpatingin ka ba sa emergency room sa nakalipas na 6 na buwan?	☐ Oo ☐ Hindi
	a) Kung oo, ilang beses ka nagpatingin sa emergency room?	
	b) (Mga) dahilan para sa (mga) pagpapatingin sa ER:	
19.	Nanatili ka ba nang magdamag sa ospital sa nakalipas na 6 na buwan?	☐ Oo ☐ Hindi
	a) Kung oo, ilang beses kang nanatili sa ospital?	
	b) Kung oo, (mga) dahilan para sa (mga) pananatili sa ospital:	

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20.	Nauunawaan mo ba kung para saan ang iyong mga gamot at kung bakit mo iniinom ang mga ito?	☐ Oo ☐ Hindi ☐ Walang inireresetang gamot ✓ Kung Hindi, inirerekomenda naming: • Ilagay ang iyong mga gamot sa isang "Brown na Bag" at dalhin ang mga ito sa iyong susunod na pagpapatingin sa doktor. O • Tawagan ang aming pharmacist sa (855) 658-0918, TTY: 711, Lunes – Biyernes, 8 a.m. – 5 p.m., na siyang magsusuri sa iyong mga gamot at sasagot sa anumang tanong.
21.	Kailangan mo ba ng tulong sa pag-inom ng iyong mga gamot?	☐ Oo ☐ Hindi
22.	Kailangan mo ba ng tulong sa pagsagot ng mga form sa kalusugan?	☐ Oo ☐ Hindi
23.	Kailangan mo ba ng tulong sa pagsagot ng mga tanong kapag nagpapatingin ka sa doktor?	☐ Oo ☐ Hindi
24.	Kumpara sa ibang kaedad mo, masasabi mo bang ang iyong kalusugan ay:	☐ Napakabuti ☐ Mahusay ☐ Mabuti ☐ Katamtaman ☐ Hindi Mabuti
25.	Nagkaroon ka ba ng anumang pagbabago sa iyong pag-iisip, pag-alala, o pagpapasya?	☐ Oo ☐ Hindi
26.	Nabakunahan ka na ba para sa trangkaso ngayong taon?	☐ Oo ☐ Hindi

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27.	Ano ang kasalukuyang sitwasyon ng iyong pamumuhay?	☐ Walang tirahan ☐ Mag-isang naninirahan ☐ Nakatira sa isang tirahan ng grupo ☐ Nakatira sa isang pasilidad ng pangangalaga ☐ Nakatira sa isang shelter ☐ Nakatira sa isang pasilidad ng may tulong na pamumuhay ☐ Nakatira kasama ang ibang pamilya ☐ Nakatira kasama ng mga hindi kamag-anak ☐ Nakatira kasama ang asawa ☐ Nakatira sa out of home placement ☐ Nakatira sa medikal na pasilidad na nasa labas ng estado ☐ Wala sa nabanggit ☐ Iba Pa
	a) Kung Iba Pa, pakisaad:	
28.	Kaya mo bang mamuhay nang ligtas at makagalaw nang maayos sa iyong bahay?	☐ Oo ☐ Hindi
29.	Kung Hindi, ang lugar bang tinitirahan mo ay may:	
	a) Maayos na ilaw	☐ Mayroon ☐ Wala
	b) Maayos na heater	☐ Mayroon ☐ Wala
	c) Maayos na cooler	☐ Mayroon ☐ Wala
	d) Mga hawakan para sa anumang hagdan o rampa	☐ Mayroon ☐ Wala ☐ N/A – Walang hagdan o rampa.

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	e) Mainit na tubig	☐ Mayroon ☐ Wala
	f) Banyo sa loob ng bahay	☐ Mayroon ☐ Wala
	g) Isang pinto palabas na nala-lock	☐ Mayroon ☐ Wala
	h) Hagdan paakyat sa bahay mo o hagdan sa loob ng iyong bahay	☐ Mayroon ☐ Wala
	i) Elevator	☐ Mayroon ☐ Wala
	j) Espasyo para makagamit ka ng wheelchair	☐ Mayroon ☐ Wala ☐ N/A – Hindi ko kailangan ng wheelchair.
	k) Maluwang na daan palabas ng iyong bahay	☐ Mayroon ☐ Wala
30.	Nakaranas ka na ba ng pagkatumba sa nakaraang buwan?	☐ Oo ☐ Hindi
31.	Takot ka bang matumba?	☐ Oo ☐ Hindi
32.	Kailangan mo ba ng tulong sa alinman sa mga pagkilos na ipinapakita sa ibaba?	
	a) Pagligo o pagsha-shower	☐ Oo ☐ Hindi
	b) Pag-akyat sa hagdan	☐ Oo ☐ Hindi
	c) Pagkain	☐ Oo ☐ Hindi
	d) Pagbibihis	☐ Oo ☐ Hindi
	e) Pagsisipilyo, pagsusuklay ng buhok, pag-aahit	☐ Oo ☐ Hindi
	f) Paghahanda ng pagkain o pagluluto	☐ Oo ☐ Hindi

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	g) Pagbangon sa higaan o pagtayo mula sa pagkakaupo	☐ Oo ☐ Hindi
	h) Pamimili at pagkuha ng pagkain	☐ Oo ☐ Hindi
	i) Pagbabanyo	☐ Oo ☐ Hindi
	j) Paglalakad	☐ Oo ☐ Hindi
	k) Paghuhugas ng mga pinggan o paglalaba ng mga damit	☐ Oo ☐ Hindi
	l) Pagsusulat ng mga tseke o pagsubaybay sa pera	☐ Oo ☐ Hindi
	m) Pagkuha ng masasakyan papunta sa doktor o para makipagkita sa mga kaibigan mo	☐ Oo ☐ Hindi
	n) Paglilinis ng bahay o paglilinis ng bakuran	☐ Oo ☐ Hindi
	o) Paglabas para bisitahin ang pamilya o mga kaibigan	☐ Oo ☐ Hindi
	p) Paggamit ng telepono	☐ Oo ☐ Hindi
	q) Pagsubaybay sa mga appointment	☐ Oo ☐ Hindi
33.	Kung oo sa alinman sa nasa itaas, nakukuha mo ba ang lahat ng tulong na kailangan mo sa mga gawaing ito?	☐ Oo ☐ Hindi
34.	Mayroon ka bang mga kapamilya o kakilalang handang tumulong at makakatulong sa iyo kapag kailangan mo ng tulong?	☐ Mayroon ☐ Wala

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35.	Naiisip mo bang nahihirapan ang iyong tagapag-alaga na tulungan ka sa tuwing kailangan mo siya?	☐ Oo ☐ Hindi ☐ Wala akong tagapag-alaga.
36.	Nauubusan ka ba minsan ng perang pambayad sa pagkain, renta, mga bayarin sa utilidad, at gamot?	☐ Oo ☐ Hindi
37.	Mayroon bang sinuman na gumagamit ng iyong pera nang walang pahintulot mo?	☐ Mayroon ☐ Wala
38.	Ang isang paunang direktiba ay isang form na nagpapaalam sa iyong mga mahal sa buhay tungkol sa mga pinili mo sa pangangalagang pangkalusugan kung malubha ang iyong karamdaman at hindi mo kayang ikaw mismo ang gumawa ng mga ito. Mayroon ka bang nakahandang living will o paunang direktiba?	☐ Mayroon ☐ Wala
	a) Kung Mayroon, anong uri ng dokumento ito?	
	b) Kung Mayroon, may kopya ba nito ang iyong PCP/Doktor?	☐ Mayroon ☐ Wala
	c) Kung Wala, maaari ba kitang padalhan ng higit pang impormasyon?	☐ Oo ☐ Hindi
39.	(Para sa Tanong 39 hanggang 44, sumagot lang kung ikaw ay 13 taong gulang o mas matanda) Sa nakalipas na tatlong buwan, naramdaman mo bang dapat mong bawasan o ihinto ang pag-inom ng alak o paggamit ng droga?	☐ Oo ☐ Hindi

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40.	Sa nakalipas na tatlong buwan, may kinainisan o napikon ka na ba dahil sinabihan kang bawasan o ihinto ang pag-inom ng alak o paggamit ng droga?	☐ Mayroon ☐ Wala
41.	Sa nakalipas na tatlong buwan, nakaramdam ka ba ng pagkakonsensya o pagkalungkot tungkol sa kung gaano karami ang iyong iniinom na alak o ginagamit na droga?	☐ Oo ☐ Hindi
42.	Sa nakalipas na tatlong buwan, nagigising ka ba dahil gusto mong uminom ng alak o gumamit ng droga?	☐ Oo ☐ Hindi
43.	Pakiramdam mo ba ay may problema ka sa droga o alak?	☐ Oo ☐ Hindi
44.	Kung oo sa tanong 39-43, gusto mo bang tawagan ka ng isang Tagapamahala ng Kaso para bigyan ka ng suporta/turuan ka?	☐ Oo ☐ Hindi
45.	Sa nakalipas na 2 linggo, gaano kadalas kang nawalan ng gana o hindi nasisiyahang gumawa ng mga bagay?	☐ Hindi naman ☐ Ilang araw ☐ Mahigit sa isang linggo ☐ Halos araw-araw
46.	Sa nakalipas na 2 linggo, gaano kadalas kang nalulungkot, nakakaramdam ng depresyon, o nawawalan ng pag-asa?	☐ Hindi naman ☐ Ilang araw ☐ Mahigit sa isang linggo ☐ Halos araw-araw
47.	Sa nakalipas na isang buwan (30 araw), ilang araw kang nakaramdam ng pagkalungkot?	☐ Wala – Hindi ako kailanman nalulungkot ☐ Mas kaunti sa 5 araw ☐ Lampas sa kalahating buwan (mahigit 15 araw) ☐ Halos araw-araw – Palagi akong nalulungkot
48.	May kinakatakutan ka bang sinuman o may nananakit ba sa iyo?	☐ Mayroon ☐ Wala

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	Salamat sa paglalaan ng oras para kumpletuhin ang survey. Posibleng may makipag-ugnayan sa iyo. Kung kailangan mo ng kaunting karagdagang tulong sa pag-aasikaso sa iyong kalusugan, maaari nating talakayin ang iyong mga pangangailangan sa isang pagpupulong ng "Interdisciplinary na Team ng Pangangalaga (Interdisciplinary Care Team)" o na tinatawag din naming "ICT." Isasama namin ang mga miyembro ng iyong team ng pangangalaga, halimbawa ang iyong doktor ng pangunahing pangangalaga, ang iyong tagapamahala ng kaso, ang iyong tagapag-alaga, at ang sarili mo. Maaaring magkita-kita ang team na ito sa personal o sa pamamagitan ng tawag sa telepono at magtutulungan ang mga miyembro nito para makabuo ng plano para matugunan ang iyong mga pangangailangan sa pangangalagang pangkalusugan. **Lumagda para patunayang nabasa at nauunawaan mo ang nasa itaas: _____**	

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Khảo sát về Sức khỏe

Tên Hội Viên: **Người Hoàn Thành Khảo Sát Này:** **Số Điện Thoại của Người Hoàn Thành Khảo Sát Này:** **Mối Quan Hệ với Hội Viên:**	**Số Điện Thoại Nhà của Hội Viên:** **Số Điện Thoại Di Động của Hội Viên:** **ID Healthcare của Hội Viên:** **Ngày Sinh của Hội Viên:** / / **<u>Ngày Hôm Nay</u>:** / /

	CÂU HỎI	TRẢ LỜI
1.	Quý vị có nhu cầu ngôn ngữ khác ngoài Tiếng Anh không?	☐ Tiếng Ả-rập ☐ Tiếng Creole ☐ Tiếng Pháp ☐ Tiếng Quan Thoại ☐ Tiếng Nga ☐ Tiếng Somali ☐ Tiếng Tây Ban Nha ☐ Tiếng Việt ☐ Không có ☐ Ngôn Ngữ Khác
2.	Nếu là Ngôn Ngữ Khác, vui lòng mô tả:	
3.	Quý vị có ưu tiên đặc biệt nào mà chúng tôi cần biết không?	Đánh dấu tất cả các lựa chọn phù hợp: ☐ Ưu Tiên Liên Quan Đến Văn Hóa Mở rộng về ưu tiên liên quan đến văn hóa: _____ ☐ Suy Giảm Thính Lực: Mở rộng về ưu tiên liên quan đến suy giảm thính lực : _____ ☐ Khả Năng Đọc Viết Mở rộng về ưu tiên liên quan đến khả năng đọc viết: _____

		☐ Nhu Cầu hoặc Ưu Tiên Liên Quan Đến Tôn Giáo/Tâm Linh Mở rộng về nhu cầu hoặc ưu tiên liên quan đến Tôn Giáo/Tâm Linh : _____ ☐ Suy Giảm Thị Lực Mở rộng về ưu tiên liên quan đến suy giảm thị lực : _____ ☐ Các Ưu Tiên Đặc Biệt Khác Mở rộng về các ưu tiên đặc biệt khác: _____ ☐ Không có
4.	Lo ngại **chính** về sức khỏe của quý vị hiện giờ là gì?	
5.	Quý vị có đang mang thai không?	☐ Có ☐ Không ☐ Không áp dụng
6.	Quý vị có bất kỳ vấn đề nào với phổi, như bệnh hen suyễn, bệnh phổi tắc nghẽn mạn tính hoặc bệnh xơ nang không?	☐ Bệnh hen suyễn ☐ Bệnh Phổi Tắc Nghẽn Mạn Tính (COPD) ☐ Bệnh Xơ Nang ☐ Không có
7.	Quý vị có bất kỳ vấn đề nào với tim hoặc hệ tuần hoàn của mình như rung nhĩ, bệnh mạch vành, bệnh động mạch ngoại vi, suy tim sung huyết hay đột quỵ không?	☐ Rung Nhĩ ☐ Bệnh Mạch Vành/Bệnh Động Mạch Ngoại Vi ☐ Suy Tim Sung Huyết ☐ Tai Biến Mạch Máu Não/Đột Quỵ

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		☐ Cao Huyết Áp ☐ Không có
8.	Quý vị có bất kỳ vấn đề nào với thận như bệnh thận mạn tính hoặc bệnh thận giai đoạn cuối phải lọc máu không?	☐ Bệnh Thận Mạn Tính ☐ Bệnh Thận Giai Đoạn Cuối Phải Lọc Máu ☐ Không có
9.	Bác sĩ của quý vị có chẩn đoán rằng quý vị mắc một tình trạng sức khỏe hành vi như trầm cảm, tâm thần phân liệt hoặc rối loạn lưỡng cực không?	☐ Trầm Cảm ☐ Tâm Thần Phân Liệt ☐ Rối Loạn Lưỡng Cực ☐ Không có
10.	Quý vị có bất kỳ tình trạng nào ảnh hưởng đến não của quý vị như co giật, trí nhớ (mất trí nhớ) hoặc đột quỵ không?	☐ Co Giật ☐ Tai Biến Mạch Máu Não/Đột Quỵ ☐ Mất Trí Nhớ ☐ Bệnh Alzheimer ☐ Các tình trạng khác liên quan đến não: _____ ☐ Không có
11.	Quý vị có bị xơ gan không?	☐ Có ☐ Không
12.	Quý vị có bị hồng cầu hình liềm không?	☐ Có ☐ Không
13.	Quý vị có bị HIV hoặc AIDS không?	☐ HIV ☐ AIDS ☐ Không
14.	Quý vị có bị ung thư hoạt động đang được điều trị bằng hóa trị, xạ trị hoặc phẫu thuật không?	☐ Có ☐ Không
15.	Quý vị có bị bệnh tiểu đường (đái tháo đường) không?	☐ Có ☐ Không
16.	Quý vị có bị viêm thấp khớp không?	☐ Có ☐ Không

17.	Các tình trạng khác	☐ Khác _____ _____ ☐ Không có
18.	Quý vị có từng đến phòng cấp cứu trong vòng 6 tháng qua không?	☐ Có ☐ Không
	a) Nếu có, quý vị đã đến phòng cấp cứu bao nhiêu lần?	
	b) (Các) Lý do đến phòng cấp cứu:	
19.	Quý vị có từng nằm viện qua đêm trong vòng 6 tháng qua không?	☐ Có ☐ Không
	a) Nếu có, quý vị đã nằm viện qua đêm bao nhiêu lần?	
	b) Nếu có, (các) lý do khiến quý vị phải nằm viện:	
20.	Quý vị có hiểu tác dụng của các loại thuốc của quý vị và tại sao quý vị lại sử dụng chúng không?	☐ Có ☐ Không ☐ Không có thuốc theo toa ✓ Nếu Không, chúng tôi khuyến nghị: • Quý vị nên cho thuốc của mình vào "Túi Nâu" và mang đến cuộc hẹn thăm khám tiếp theo với bác sĩ của quý vị. HOẶC • Gọi điện cho dược sĩ của chúng tôi theo số (855) 658-0918, TTY: 711, Thứ Hai - Thứ

		Sáu, 8 giờ sáng - 5 giờ chiều để dược sĩ xem xét các loại thuốc của quý vị cùng quý vị và trả lời bất kỳ câu hỏi nào.
21.	Quý vị có cần được trợ giúp để uống thuốc không?	☐ Có ☐ Không
22.	Quý vị có cần được trợ giúp để điền các biểu mẫu sức khỏe không?	☐ Có ☐ Không
23.	Quý vị có cần được trợ giúp để trả lời các câu hỏi trong buổi thăm khám với bác sĩ không?	☐ Có ☐ Không
24.	So với những người khác cùng độ tuổi, quý vị thấy sức khỏe của mình:	☐ Tuyệt Vời ☐ Rất Tốt ☐ Tốt ☐ Bình Thường ☐ Kém
25.	Quý vị có bất kỳ thay đổi nào trong việc suy nghĩ, ghi nhớ hoặc đưa ra quyết định không?	☐ Có ☐ Không
26.	Quý vị đã tiêm phòng cúm năm nay chưa?	☐ Có ☐ Không
27.	Hoàn cảnh sống hiện tại của quý vị là gì?	☐ Vô gia cư ☐ Sống một mình ☐ Sống trong nhà chung ☐ Sống tại cơ sở điều dưỡng

		☐ Sống tại nhà trú ẩn ☐ Sống tại cơ sở hỗ trợ sinh hoạt ☐ Sống với gia đình khác ☐ Sống với những người không phải là họ hàng ☐ Sống với vợ/chồng ☐ Không được sống tại nhà ☐ Sống tại cơ sở y tế ngoài tiểu bang ☐ Không có điều nào ở trên ☐ Khác
	a) Nếu Khác, vui lòng mô tả:	
28.	Quý vị có thể sống một cách an toàn và di chuyển dễ dàng quanh nhà không?	☐ Có ☐ Không
29.	Nếu Không, nơi quý vị sống có:	
	a) Hệ thống đèn đủ sáng	☐ Có ☐ Không
	b) Hệ thống sưởi đủ ấm	☐ Có ☐ Không
	c) Hệ thống làm mát tốt	☐ Có ☐ Không
	d) Lan can cho cầu thang hoặc đường dốc	☐ Có ☐ Không ☐ Không áp dụng - Không có cầu thang hoặc đường dốc.
	e) Nước nóng	☐ Có ☐ Không
	f) Nhà vệ sinh trong nhà	☐ Có ☐ Không
	g) Cửa khóa bên ngoài	☐ Có ☐ Không
	h) Cầu thang để vào nhà hoặc cầu thang trong nhà	☐ Có ☐ Không

	i) Thang máy	☐ Có ☐ Không
	j) Không gian để sử dụng xe lăn	☐ Có ☐ Không ☐ Không áp dụng - Tôi không cần xe lăn.
	k) Đường thông thoáng để ra khỏi nhà	☐ Có ☐ Không
30.	Quý vị có bị té ngã trong tháng trước không?	☐ Có ☐ Không
31.	Quý vị có sợ bị té ngã không?	☐ Có ☐ Không
32.	Quý vị có cần được trợ giúp với bất kỳ hoạt động nào dưới đây không?	
	a) Tắm bồn hoặc vòi hoa sen	☐ Có ☐ Không
	b) Lên cầu thang	☐ Có ☐ Không
	c) Ăn uống	☐ Có ☐ Không
	d) Mặc quần áo	☐ Có ☐ Không
	e) Đánh răng, chải đầu, cạo râu	☐ Có ☐ Không
	f) Chuẩn bị đồ ăn hoặc nấu nướng	☐ Có ☐ Không
	g) Ra khỏi giường hoặc ghế	☐ Có ☐ Không
	h) Mua sắm và mua đồ ăn	☐ Có ☐ Không
	i) Sử dụng nhà vệ sinh	☐ Có ☐ Không
	j) Đi lại	☐ Có ☐ Không
	k) Rửa bát hoặc giặt quần áo	☐ Có ☐ Không
	l) Viết séc hoặc theo dõi tiền bạc	☐ Có ☐ Không
	m) Đi đến bác sĩ hoặc gặp bạn bè	☐ Có ☐ Không

	n) Làm việc nhà hoặc làm vườn	☐ Có ☐ Không
	o) Ra ngoài để đi thăm gia đình hoặc bạn bè	☐ Có ☐ Không
	p) Sử dụng điện thoại	☐ Có ☐ Không
	q) Theo dõi các cuộc hẹn	☐ Có ☐ Không
33.	Nếu quý vị trả lời có cho bất kỳ câu nào phía trên, thì quý vị có đang nhận được mọi sự trợ giúp mà quý vị cần cho những hoạt động đó không?	☐ Có ☐ Không
34.	Quý vị có người thân trong gia đình hay người nào sẵn sàng và có thể trợ giúp quý vị khi quý vị cần không?	☐ Có ☐ Không
35.	Quý vị có từng nghĩ rằng người chăm sóc của quý vị đã rất vất vả để cung cấp cho quý vị mọi sự trợ giúp mà quý vị cần không?	☐ Có ☐ Không ☐ Tôi không có người chăm sóc.
36.	Quý vị có thỉnh thoảng bị hết tiền để thanh toán tiền đồ ăn, tiền thuê nhà, hóa đơn và thuốc men không?	☐ Có ☐ Không
37.	Có người nào sử dụng tiền của quý vị mà không có sự đồng ý của quý vị không?	☐ Có ☐ Không
38.	Chỉ thị trước là một biểu mẫu thông báo cho những người thân của quý vị biết các lựa chọn về chăm sóc sức khỏe của quý vị nếu quý vị quá yếu để tự đưa ra lựa chọn. Quý vị có di chúc sống hoặc chỉ thị trước không?	☐ Có ☐ Không
	a) Nếu Có, đó là loại tài liệu nào?	

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	b) Nếu Có, PCP/Bác Sĩ của quý vị có bản sao của tài liệu đó không?	☐ Có ☐ Không
	c) Nếu Không, tôi có thể gửi cho quý vị thêm thông tin không?	☐ Có ☐ Không
39.	(Chỉ trả lời các Câu Hỏi 39 đến 44 nếu từ 13 tuổi trở lên) Trong ba tháng qua, quý vị đã từng cảm thấy quý vị nên giảm hoặc ngừng uống rượu bia hay sử dụng chất gây nghiện chưa?	☐ Có ☐ Không
40.	Trong ba tháng qua, có ai làm quý vị bực mình hoặc khó chịu khi yêu cầu quý vị giảm hoặc ngừng uống rượu bia hay sử dụng chất gây nghiện không?	☐ Có ☐ Không
41.	Trong ba tháng qua, quý vị có cảm thấy tội lỗi hay tồi tệ về số rượu bia hay chất gây nghiện mà quý vị sử dụng không?	☐ Có ☐ Không
42.	Trong ba tháng qua, có khi nào quý vị tỉnh giấc và muốn uống rượu bia hay sử dụng chất gây nghiện không?	☐ Có ☐ Không
43.	Quý vị có cảm thấy quý vị có vấn đề với chất gây nghiện hay rượu bia không?	☐ Có ☐ Không
44.	Nếu trả lời có cho câu hỏi 39-43, quý vị có muốn một Nhân Viên Quản Lý Trường Hợp gọi điện cho quý vị để hỗ trợ/cung cấp thông tin không?	☐ Có ☐ Không
45.	Trong 2 tuần qua, tần suất quý vị cảm thấy ít hứng thú hoặc vui vẻ khi làm việc?	☐ Không có ☐ Một vài ngày ☐ Nhiều hơn một nửa số ngày ☐ Gần như mỗi ngày
46.	Trong 2 tuần qua, tần suất quý vị cảm thấy thất vọng, chán nản hoặc tuyệt vọng?	☐ Không có ☐ Một vài ngày ☐ Nhiều hơn một nửa số ngày

200 Oceangate, Suite 100
Long Beach, CA 90802

		☐ Gần như mỗi ngày
47.	Trong tháng qua (30 ngày), số ngày quý vị cảm thấy cô đơn?	☐ Không có - Tôi chưa bao giờ cảm thấy cô đơn ☐ Dưới 5 ngày ☐ Nhiều hơn một nửa số ngày (nhiều hơn 15 ngày) ☐ Hầu hết các ngày - Tôi luôn cảm thấy cô đơn
48.	Quý vị có sợ ai đó hoặc có ai đó đang làm tổn thương quý vị không?	☐ Có ☐ Không
	Cảm ơn quý vị đã dành thời gian hoàn thành khảo sát này. Có thể sẽ có người liên hệ với quý vị. Nếu quý vị cần được trợ giúp thêm trong việc chăm sóc sức khỏe của mình, chúng ta có thể thảo luận về các nhu cầu của quý vị trong cuộc họp của "Nhóm Chăm Sóc Liên Ngành" hay còn gọi là "ICT". Chúng tôi sẽ đưa vào các thành viên trong nhóm chăm sóc của quý vị, ví dụ như bác sĩ chăm sóc chính, nhân viên quản lý trường hợp, người chăm sóc của quý vị và bản thân quý vị. Nhóm này có thể họp mặt trực tiếp hoặc qua điện thoại và làm việc cùng nhau để lập một kế hoạch đáp ứng các nhu cầu về chăm sóc sức khỏe của quý vị. **Vui lòng ký tắt rằng quý vị đã đọc và hiểu những thông tin phía trên: _____**	

MOLINA HEALTHCARE

"TAGLINES"

Send with all notices

TAGLINES

English Tagline

ATTENTION: If you need help in your language call 1-888-665-4621 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-888-665-4621 (TTY: 711). These services are free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل ب 1-888-665-4621 (711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-888-665-4621 (711). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-888-665-4621 (TTY: 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-888-665-4621 (TTY: 711): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-888-665-4621 (TTY: 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-888-665-4621 (TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 [1-xxx-xxx-xxxx] (TTY: [1-xxx-xxx-xxxx])。另外还提供针对残疾人士的帮助和服务，例如文盲和需要较大字体阅读，也是方便取用的。请致电 1-888-665-4621 (TTY: 711)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-888-665-4621 (TTY: 711) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-888-665-4621 (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

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हिंदी टैगलाइन (Hindi)
ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो [1-xxx-xxx-xxxx] (TTY: [1-xxx-xxx-xxxx]) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-888-665-4621 (TTY: 711) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-888-665-4621 (TTY: 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-888-665-4621 (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)
注意日本語での対応が必要な場合は 1-888-665-4621 (TTY: 711)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-888-665-4621 (TTY: 711) へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)
유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-888-665-4621 (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-888-665-4621 (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)
ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-888-665-4621 (TTY: 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ 1-888-665-4621 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)
LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-888-665-4621 (711]). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-888-665-4621 (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-888-665-4621

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(711). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ 1-888-665-4621 (TTY: 711).
ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский слоган (Russian)
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-888-665-4621 (711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-888-665-4621 (линия TTY: 711). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)
ATENCIÓN: si necesita ayuda en su idioma, llame al [1-xxx-xxx-xxxx] (TTY: [1-xxx-xxx-xxxx]). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-888-665-4621 (TTY: 711). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-888-665-4621 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-888-665-4621 (TTY: 711). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-888-665-4621 (TTY: 711) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ
ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-888-665-4621 (TTY: 711) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-888-665-4621 (TTY: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-888-665-4621 (TTY: 711). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-888-665-4621 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-888-665-4621 (TTY: 711). Các dịch vụ này đều miễn phí.

Send with all notices

NONDISCRIMINATION NOTICE

Discrimination is against the law. *Molina Healthcare follows* State and Federal civil rights laws. *Molina Healthcare* does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Molina Healthcare provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact *Molina Healthcare 7:00am-7:00pm* by calling *1-888-665-4621.* If you cannot hear or speak well, please call *711* . Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

Molina Healthcare
Civil Rights Coordinator
200 Ocean Gate, Suite 100
Long Beach CA 90202

HOW TO FILE A GRIEVANCE

If you believe that *Molina Healthcare* has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with *Molina Healthcare's Civil Rights Coordinator*. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact *Molina Healthcare's Civil Rights Coordinator* between *8:30-5:30 p.m.* by calling*1-866-606-3889.* Or, if you cannot hear or speak well, please call *711*

- In writing: Fill out a complaint form or write a letter and send it to:

Molina Healthcare
Civil Rights Coordinator
200 Ocean Gate, Suite 100
Long Beach CA 90202

- In person: Visit your doctor's office or *Molina Healthcare* and say you want to file a grievance.

- Electronically: Visit *Molina Healthcare's* website at *www.molinahealthcare.com.*

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.

- In writing: Fill out a complaint form or send a letter to:

Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

200 Oceangate, Suite 100
Long Beach, CA 90802

<Date>

<Member Name>
<Member Address Line 1>
<Member Address Line 2>

Dear <Member Name>:

Molina Healthcare and <ECM Provider Name> aim to keep you healthy. We want to improve your wellbeing. The Enhanced Care Management (ECM) benefit provides coordination of care and services. ECM offers services and resources to help meet your needs. This benefit is available at no cost to you.

Care Plan
Thank you for speaking with me about your needs. Enclosed is a copy of your care plan. Please review your care plan and continue working on the goals we discussed. I will keep in contact with you and can give you support to help you meet your goals.

Care Team
You can contact me to ask for an ECM care team meeting. A care team includes individuals that are involved in your care. You can choose who may join the team. The team can meet to discuss your concerns. The meeting may be in person or by phone. The team can give ideas to help manage your health.

Other services Molina offers:

- *Nurse Advice Line.*
  Nurses can answer health questions or concerns. This service does not replace the care from a doctor. This service is available at no cost to you. Call (888) 275-8750, TTY users can dial 711. This service is open 24 hours a day, 7 days a week, local time.
- *Member Services Contact Center.*
  Customer service agents can help with plan benefits and services. An agent can help you choose or change your primary care doctor. Call (888) 665-4621, TTY users can dial 711. Hours are 7 a.m. to 7 p.m. local time, Monday – Friday.
- *Transport Services*.
  Rides for Medi-Cal covered services are available. Schedule your ride at least 3 days before the visit. Limits may apply. Call American Logistics Transportation at (844) 292-2688, TTY users can dial 711. Hours are 8 a.m. to 8 p.m. local time, Monday – Friday.

Please contact me if you have any questions about the program or your care plan. Call <(XXX) XXX-XXXX - XXXXXX>, TTY users can dial 711. Our hours are <8:00 a.m. to 5:00 p.m. local time, Monday – Friday>. If there is no answer, you may leave a voicemail. Be sure to say your name, phone number, and the best time to call you back.

Sincerely,

<Name>
<ECM Provider Name>

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OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.

- In writing: Fill out a complaint form or send a letter to:

Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Complaint forms are available at
http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Send with all notices

"TAGLINES"

TAGLINES

English Tagline
ATTENTION: If you need help in your language 1-888-665-4621 (TTY: 711) . Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-888-665-4621 (TTY: 711). These services are free of charge.

الشعار بالعربية (Arabic)
يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-888-665-4621 (711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-888-665-4621 (711). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-888-665-4621 (TTY: 711) : Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-888-665-4621 (TTY: 711)): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)
ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-888-665-4621 (TTY: 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរធំ សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-888-665-4621 (TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)
请注意：如果您需要以您的母语提供帮助，请致电 1-888-665-4621 (TTY: 711)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 1-888-665-4621 (TTY: 711)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)
توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-888-665-4621 (TTY: 711) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-888-665-4621 (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

Send with all notices

हिंदी टैगलाइन (Hindi)
ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-888-665-4621 (TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-888-665-4621 (TTY: 711) पर कॉल करें। ये सेवाएं निःशुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu 1-888-665-4621 (TTY: 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-888-665-4621 (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)
注意日本語での対応が必要な場合は 1-888-665-4621 (TTY: 711) へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-888-665-4621 (TTY: 711) へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)
유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-888-665-4621 (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-888-665-4621 (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)
ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-888-665-4621 (TTY: 711) . ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ 1-888-665-4621 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)
LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-888-665-4621 (711]). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-888-665-4621 (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-888-665-4621 (711) . ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ □ਹਾਇਤਾ ਅਤੇ □ੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦ□ਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ 1-888-665-4621 (711). ਇਹ □ੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Send with all notices

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200 Oceangate, Suite 100
Long Beach, CA 90802

<Date>

<Member Name>
<Member Address Line 1>
<Member Address Line 2>

Dear <Member Name>,

I have tried to call you and have been unable to reach you. I have important information for you. Please call me at:

<(XXX)XXX-XXXX, ext. XXXXXX>,
<Monday through Friday, between 8:00 am and 5:00 pm, TTY: 711.>

If I do not answer, this is because I am on the phone with other members. Please leave a message with a phone number where I can reach you. Also, let me know the best time to call you. Thank you!

I hope to hear from you soon.

Sincerely,

<Staff Name>
<Molina Healthcare of California or ECM Provider Name>

200 Oceangate, Suite 100
Long Beach, CA 90802

<Date>

<Provider Name>
<Provider Address Line 1>
<Provider Address Line 2>

Dear <Provider Name>:

[Member ID: <0000000000>]
[Member Name: <Member Name>]
[Member Date of Birth: <Date of Birth>]
[Member Address: <Street Address>]
[<City, State Zip>]
[Member Phone Number: <(000) 000-0000>]

Molina Healthcare aims to collaborate with you in the care of our members. The member referenced in this letter is currently participating in Enhanced Care Management (ECM). Through ECM, members are assigned to an ECM Provider that will assist with case management and care coordination needs. The ECM Provider is a care coordination team and will work together with you, the Primary Care Physician, as well other providers and community organizations. This program offers an additional layer of support for the member.

We ask for your participation in the development and implementation of this member's care plan. We have enclosed a copy of member's care plan for your review. Please call <ECM Provider> at <(XXX) XXX-XXXX - XXXXXX> to get connected with the Lead Care Manager or to request a care team meeting. Our hours are <8:00 a.m. to 5:00 p.m. local time, Monday – Friday>.

We look forward to collaborating with you.

Sincerely,

<Staff Name>
<ECM Provider Name>

200 Oceangate, Suite 100
Long Beach, CA 90802

<Date>

<Provider Name>
<Provider Address Line 1>
<Provider Address Line 2>

Dear <PCP Name>,

[Member ID: <0000000000>]
[Member Name: <Member Name>]
[Member Date of Birth: <Date of Birth>]
[Member Address: <Street Address>]
[<City, State Zip>]
[Member Phone Number: <(000) 000-0000>]

This notice is to inform you that your member, <Insert Member Name>, has agreed to enroll in Enhanced Care Management (ECM) through Molina.

The member will be receiving supportive case management services through ECM. As part of the program, the assigned Lead Care Manager will assist the member with:

- Finding doctors and get appointments for health-related services;
- Better understand and tracking of medications;
- Scheduling transportation;
- Finding and applying for community-based services based on identified needs, such as housing supports or medically nutritious food; and
- Get follow-up care after discharging from the hospital.

The Lead Care Manager will be working with the member to develop an individualized care plan. The care plan will be shared with you for your input and feedback as a key member of the care team. The Lead Care Manager may also reach out to you for care coordination purposes as they work with the member on achieving their goals.

Enrollment in ECM is offered at no cost to the member and does not impact assignment to you as a PCP or any of the benefits offered under the Medi-Cal program. We believe you will find ECM is helpful in supporting positive outcomes for your assigned member. Thank you for your collaboration and support in caring for our members.

If you have any questions about ECM, please contact Molina Member Services at 1 (888) 665-4621, Monday through Friday, from 7:00 AM to 7:00 PM, TTY: 711.

Sincerely,

Molina Healthcare of California

200 Oceangate, Suite 100
Long Beach, CA 90802

<Date>

<Member Name>
<Member Address Line 1>
<Member Address Line 2>

Dear <Member Name>:

Molina Healthcare aims to keep you healthy. The Enhanced Care Management (ECM) benefit provides coordination of care and services.

I understand you no longer want to take part in ECM. This does not affect your membership to the health plan.

If you want to re-enroll in ECM, please contact Molina Member Services at (888) 665-4621, TTY users can dial 711. Our hours are 7:00 a.m. to 7:00 p.m. local time, Monday – Friday.

Other services Molina offers:

- *Nurse Advice Line.*
  Nurses can answer health questions or concerns. This service does not replace the care from a doctor. This service is available at no cost to you. Call (888) 275-8750, TTY users can dial 711. This service is open 24 hours a day, 7 days a week, local time.
- *Member Services Contact Center.*
  Customer service agents can help with plan benefits and services. An agent can help you choose or change your primary care doctor. Call (888) 665-4621, TTY users can dial 711. Hours are 7 a.m. to 7 p.m. local time, Monday – Friday.
- *Transport Services*.
  Rides for Medi-Cal covered services are available. Schedule your ride at least 3 days before the visit. Limits may apply. Call American Logistics Transportation at (844) 292-2688, TTY users can dial 711. Hours are 8 a.m. to 8 p.m. local time, Monday – Friday.

Sincerely,

<Name>
<Staff Title>

MOLINA HEALTHCARE
Your Extended Family

"NONDISCRIMINATION"

NONDISCRIMINATION NOTICE

Discrimination is against the law. Molina Healthcare follows State and Federal civil rights laws. Molina Healthcare does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Molina Healthcare provides:

- Free aids and services to people with disabilities to help them communicate better, such as:

  ✓ Qualified sign language interpreters
  ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:

  ✓ Qualified interpreters
  ✓ Information written in other languages

If you need these services, contact Molina Healthcare between 7:00 a.m.-7:00 p.m. by calling 1-888-665-4621. Or, if you cannot hear or speak well, please call 711.

MOLINA HEALTHCARE
Your Extended Family

HOW TO FILE A GRIEVANCE

If you believe that Molina Healthcare has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Molina Healthcare's Civil Rights Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact Molina Healthcare's Civil Rights Coordinator between 8:30 a.m.-5:30 p.m. by calling **1-866-606-3889**. Or, if you cannot hear or speak well, please call **711**.

- In writing: Fill out a complaint form or write a letter and send it to:

  Molina Healthcare of California
  Civil Rights Coordinator
  200 Oceangate, Suite 100
  Long Beach, CA 90802
  Fax: 310-507-6186

- In person: Visit your doctor's office or Molina Healthcare and say you want to file a grievance.

- Electronically: Visit Molina Healthcare's website at www.molinahealthcare.com or email civil.rights@molinahealthcare.com.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.

- In writing: Fill out a complaint form or send a letter to:

  Michele Villados

MOLINA HEALTHCARE
Your Extended Family

Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex , you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-665-4621 (TTY: 711).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-665-4621 (TTY: 711).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-665-4621 (TTY: 711).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-665-4621 (TTY: 711).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-665-4621 (TTY: 711)번으로 전화해 주십시오.

繁體中文(Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-665-4621 (TTY: 711)。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-888-665-4621 (TTY (հեռատիպ)՝ 711):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-665-4621 (телетайп: 711).

MOLINA HEALTHCARE
Your Extended Family

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-665-4621 (TTY: 711) تماس بگیرید.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-665-4621 (TTY: 711) まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-665-4621 (TTY: 711).

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-665-4621 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-665-4621

(رقم هاتف الصم والبكم: 711).

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-665-4621 (TTY: 711) पर कॉल करें।

ภาษาไทย (Thai)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-665-4621 (TTY: 711).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, បសវាជំនួយខ្នកភាសា ជោយមិនគិតឈ្លួ
គឺអាចមានសំរារំបើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-665-4621 (TTY: 711)។

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,
ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-665-4621 (TTY: 711).

200 Oceangate, Suite 100
Long Beach, CA 90802

<Date>

<Member Name>
<Member Address Line 1>
<Member Address Line 2>

Dear <Member Name>

I have been unable to reach you at <(XXX) XXX-XXXX>. I want to help you reach your health goals we've been working on together through Enhanced Care Management (ECM).

Please contact me as soon as possible. Call <(XXX) XXX-XXXX - XXXXXX>, TTY users can dial 711. Our hours are <8:00 a.m. to 5:00 p.m. local time, Monday – Friday>. If there is no answer, you may leave a voicemail. Be sure to say your name, phone number, and the best time to call you back.

Sincerely,

<Staff Name>
<ECM Provider Name>

200 Oceangate, Suite 100
Long Beach, CA 90802

<Date>

<Member Name>
<Member Address Line 1>
<Member Address Line 2>

Dear <Member Name>,

Thank you for enrolling in Enhanced Care Management (ECM). Your ECM provider is <ECM Provider Name>. A Lead Care Manager from < ECM Provider Name > will be calling you to find how we can help you. You may also contact them directly at <(XXX) XXX-XXXX> - <XXXXXX>.

We believe you will find ECM helpful to get the care you need. We will work with you and your doctor to help you. Thank you again for your participation in ECM.

Sincerely,

<Staff Name>
<Molina Healthcare of California>

200 Oceangate, Suite 100
Long Beach, CA 90802

<Date>

<Provider Name>
<Provider Address Line 1>
<Provider Address Line 2>

Dear <PCP Name>,

[Member ID: <0000000000>]
[Member Name: <Member Name>]
[Member Date of Birth: <Date of Birth>]
[Member Address: <Street Address>]
[<City, State Zip>]
[Member Phone Number: <(000) 000-0000>]

Molina Healthcare Enhanced Care Management (ECM) Lead Care Managers routinely engage our members in biopsychosocial assessments which include screening for depression. Your patient, XXXXXXXXX, with a birthdate of XX/XX/XXXX, scored X on a validated depression screening tool called the Patient Health Questionnaire 9 (PHQ9).
PHQ9 scores are associated with treatment recommendations as outlined below:

PHQ 9 Depression Screening Interpretation and Recommendations		
Total Score	**Level of Risk**	**Recommendations for Follow up**
0-4	None	Dialogue about any increase in symptoms
5-9	Mild	Watchful waiting. Repeat screening at follow up
10-14	Moderate	Treatment plan, consider counseling, follow up and/or pharmacotherapy
15-19	Moderately severe	Immediate initiation of pharmacotherapy and/or psychotherapy
20-27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management.

If you need any support from the health plan regarding connecting to a specialist, please contact us. In addition if your patient or their family needs additional support, please refer to your local National Alliance on Mental Illness (NAMI).

Thank you for your willingness to follow up on the results of the screening.

NAME OF ECM LCM
Molina Healthcare ECM Provider
Telephone Number: XXX - XXX - XXXX ext. XXXX

Sincerely,

Molina Healthcare of California

200 Oceangate, Suite 100
Long Beach, CA 90802

<Date>

<Provider Name>
<Provider Address Line 1>
<Provider Address Line 2>

Dear <PCP Name>,

[Member ID: <0000000000>]
[Member Name: <Member Name>]
[Member Date of Birth: <Date of Birth>]
[Member Address: <Street Address>]
[<City, State Zip>]
[Member Phone Number: <(000) 000-0000>]

Molina Healthcare Enhanced Care Management (ECM) Lead Care Managers routinely engage our members in biopsychosocial assessments. Your patient, XXXXXXXXX, with a birthdate of XX/XX/XXXX, has scored X on a validated screening tool called the Primary Care Post Traumatic Stress Disorder-5 (PC PTSD-5). The PC PTSD-5 contains five questions that ask about past traumatic experiences and current or recent symptoms of stressor-related disorders. It is recommended that people who score a **3 or above** receive further psychological evaluation and linkage with support and treatment respective to their individual needs and preferences.

If you need any support from the health plan regarding connecting to a specialist, please contact us. In addition if your patient or their family needs additional support, please refer to your local National Alliance on Mental Illness (NAMI).

Thank you for your willingness to follow up on the results of the screening.

NAME OF ECM LCM
Molina Healthcare ECM Provider
Telephone Number: XXX - XXX - XXXX ext. XXXX

Sincerely,

Molina Healthcare of California

SAN BERNARDINO COUNTY | Aging and Adult Services

IN-HOME SUPPORTIVE SERVICES (IHSS) SCREENING/REFERRAL FORM

CENTRAL INTAKE UNIT: 1 (877) 800-4544

Application Date:	**Walk In** ☐	**Referral Taken By:**	**Phone Number:**

SECTION 1 – APPLICANT INFORMATION

First Name:	MI:	Last Name:	SSN:	DOB:

Home address: City:	Zip Code:	Phone Number:	Type: Home ☐ Cell ☐ Message ☐

Mailing address same as home address ☐	Mailing Address *(If different than home address)*:

Gender: Male ☐ Female ☐	Ethnicity:	Spoken Language: Written Language:
Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Minor ☐		Applicant Income: $ Income Source:

SECTION 2 – REFERRING PARTY/CONSENT

Referring Party: Name:	Relationship:	Phone Number:

Consent for IHSS Application given by: Client ☐ Other ☐ Who: No Consent ☐ Why?:

Emergency Contact NOT living in household:
Name: Relationship: Phone Number:

SECTION 3 - HOUSEHOLD COMPOSITION

Number of Adults in the Home:	**Number of Minors in the Home:**		
List Persons in the home First and Last Name	**Relationship**	**SSN/DOB (only needed for parent/guardian of minor child who needs to apply for Medi-Cal)**	**Receiving IHSS**
			☐
			☐
			☐
			☐
			☐
			☐

Potential Safety Concerns: Health Precaution ☐ Pets ☐ Gated ☐ Hearing Impaired ☐ Visually Impaired ☐
Other ☐ Please List:

SECTION 4 – REASONS FOR REFERRAL

Have you had a medical emergency in the last 2 months: No ☐ Yes ☐ Please explain:

Were you hospitalized for at least 2 days within the last 2 months? No ☐ Yes ☐ | Are you currently in the hospital? No ☐ Yes ☐

Do you currently receive hospice or in-home nursing? No ☐ Yes ☐ What services are provided?

Medical Equipment Used *(Example: cane, wheelchair, feeding tube, oxygen)*:

Assistance needed with *(Please check all that apply – the IHSS Social Worker will still assess for all services)*:

☐ Ambulation	☐ Bathing/Grooming	☐ Bowel & Bladder	☐ Domestics	☐ Dressing
☐ Feeding	☐ Laundry	☐ Meal Prep	☐ Medication Management	
☐ Protective Supervision	☐ Shopping/Errands	☐ Transfer	☐ Transportation to Doctor	
☐ Other, Please list:				

Do you have someone currently helping you? No ☐ Yes ☐ Name:
Relationship: Phone Number:

County Use Only	No Medi-Cal ☐ Foster Care ☐ Adoption Assistance Program (Pseudo SSN) ☐ Previous IP ☐ Recipient ☐ Case # Date closed

Fax completed IHSS Screening/Referral Form to **CIU: (909) 948-6560** or **email to: DAASCIU (DAASCIU@hss.sbcounty.gov)**. Maintain original in District Office.

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

APPLICATION FOR SOCIAL SERVICES

To the Applicant: All sections of this form must be completed. Information provided is subject to verification.

NOTE: Retain your copy of your completed application. Regarding your Social Security Number, it is mandatory that you provide your Social Security Number(s) as required in 42 USC 405 and MPP Section 30-769.71. This information will be used in eligibility determination and coordinating information with other public agencies.

Date of Application:	Case Number (if known):

Section 1 – Personal Information

Name:		Social Security Number:
Street Address:		City:
State:	Zip Code:	Telephone:
Birthdate:	Sex: ☐ Male ☐ Female	

Section 2 – Veteran Information

Are you a Veteran? ☐ Yes ☐ No	Are you a Spouse/Child of a Veteran? ☐ Yes ☐ No .
If YES, give Veteran name and Claim Number:	

Section 3 – SSI/SSP Information

Do you receive SSI/SSP benefits? ☐ Yes ☐ No
If yes, check your type of living arrangement: ☐ Independent Living ☐ Board and Care ☐ Home of Another
Services being requested:

Section 4 – Past IHSS Information

Have you received In-Home Support Services (IHSS) in the past? ☐ Yes ☐ No	
If Yes, complete the following. Date and county where service was last received:	
Total Monthly Hours:	Name Used (if different from above):

Section 5 – Household Information

List Family Members in Household:

Name of: ☐ Spouse ☐ Parent	
Birthdate:	Social Security Number:
Name of: ☐ Child ☐ Other Relative	
Birthdate:	Social Security Number:
Name of: ☐ Child ☐ Other Relative	
Birthdate:	Social Security Number:
Name of: ☐ Child ☐ Other Relative	
Birthdate:	Social Security Number:
Name of: ☐ Child ☐ Other Relative	
Birthdate:	Social Security Number:

Section 6 – Ethnic and Language Information

The law requires that information on ethnic origin and primary language be collected. If you do not complete this section, social service staff will make a determination. The information will not affect your eligibility for service.

A. My Ethnic Origin is: Please choose one (See Page 7 for a list of Ethnicities and Codes)	B. I speak and understand English: ☐ Yes ☐ No If not English, my primary language is: Please choose one (See Page 7 for a list of Languages and codes)

Section 7 – Communication Accommodations

To accommodate blind or visually-impaired applicants, IHSS information is available in the following alternative formats. Please indicate which format you would prefer, if applicable. Providing information in this section will not affect your eligibility for services.

I am Blind: ☐ Yes ☐ No

If yes, please choose one of the following for each of the three types of DSS documents listed.

For Notices of Action: ☐ No accommodation is needed ☐ Braille Documents ☐ Audio CD ☐ Data CD ☐ County Support
(If County Support, describe requested support)
For IHSS Required forms: ☐ No accommodation is needed ☐ Braille Documents ☐ Audio CD ☐ Data CD ☐ County Support
(If County Support, describe requested support)
For Timesheets: ☐ No accommodation is needed ☐ Telephonic System (4 Digit RAN:) ☐ County Support
(If County Support, describe support requesting)

I am Visually Impaired:	☐ Yes	☐ No

If yes, please choose one of the following for each of the three types of DSS documents listed.

For Notices of Action: ☐ No accommodation is needed ☐ 18 Point font documents ☐ Audio CD ☐ Data CD ☐ County Support
(If County Support, describe requested support)
For IHSS Required forms: ☐ No accommodation is needed ☐ 18 Point font documents ☐ Audio CD ☐ Data CD ☐ County Support
(If County Support, describe requested support)
For Timesheets: ☐ No accommodation is needed ☐ 18 point font documents ☐ County Support
(If County Support, describe requested support, including blind-only services)

Section 8 – Affirmation

I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future.

I also understand that as the employer of my IHSS provider(s) I am responsible for:

1) Hiring, training, supervising, scheduling and, when necessary, firing my provider(s).
2) Ensuring the total hours reported by all providers who work for me do not exceed my IHSS authorized hours each month.
3) Referring any individual I want to hire to the County IHSS office to complete the provider eligibility process.
4) Notify the County IHSS office when I hire or fire a provider.

In addition, I understand and agree to the following terms and limitations regarding payment for services by the IHSS program:

1) In order for any individual to be paid by the IHSS program, they must be approved as an IHSS eligible provider.
2) If I choose to have an individual work for me who has not yet been approved as an eligible IHSS provider, I will be responsible for paying him/her if he/she is not approved.
3) The IHSS program will not pay for any services provided to me until my application for services is approved and then will only pay for those services that are authorized for me to receive by the IHSS Program.
4) I will be responsible for paying for any services I receive that are not included in my IHSS authorization.

I also understand and agree to cooperate with the following as a part of my eligibility for IHSS:

To promote program integrity, I may be subject to unannounced visits to my home and that I or my provider(s) may receive letters identifying program requirement concerns from the State Department of Health Care Services (DHCS), California Department of Social Services (CDSS) and/or the County in which I receive services.

The purpose of the visits and letters is to ensure that program requirements are being followed and that the authorized services are necessary for you to remain safely in your home. The visit will also verify that the authorized services are being provided, that the quality of those services is acceptable, and that your well-being is protected.

If it is found that IHSS services are not required or not being properly provided, you and/or your provider may be subject to a Medi-Cal fraud investigation. If fraud is substantiated, you and/or your provider will be prosecuted for Medi-Cal fraud.

Section 9 – Signature(s)

Signature of Applicant:	Date:
Signature of Applicant's Representative (only if applicable):	Date:
Representative's Relationship to Applicant (only if applicable):	Representative Telephone Number (only if applicable):
Representative's Address (only if applicable):	

To report suspected fraud or abuse in the provision or receipt of IHSS services, please call the fraud hotline at 1-800-822-6222, email at stopmedicalfraud@dhcs.ca.gov , or go to http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx .

FOR AGENCY USE ONLY

Income Eligible: ☐ Yes ☐ No	Status Eligible: ☐ Yes ☐ No	Verification:
Signature of Social Worker or Agency Representative:		Telephone Number:
Recipient Status: ☐ Refugee ☐ Cuban/Haitian Entrant ☐ Neither	Source of Verification for Refuge or Entrant Status (explain):	

Ethnic Codes:

1. White.
2. Hispanic.
3. Black.
4. Other Asian or Pacific Islander.
5. American Indian or Alaskan Native.
7. Filipino.
C. Chinese.
H. Cambodian.
J. Japanese.
K. Korean.
M. Samoan.
N. Asian Indian.
P. Hawaiian.
R. Guamanian.
T. Laotian.
V. Vietnamese.

Language Codes:

O. American Sign Language (AMISLAN or ASL).
1. Spanish - NOA will be issued in Spanish.
2. Cantonese.
3. Japanese.
4. Korean.
5. Tagalog.
6. Other non-English.
7. English.
9. Spanish - NOA will be issued in English.
A. Other Sign Language.
B. Mandarin.
C. Other Chinese Languages.
D. Cambodian.
E. Armenian.
F. Ilacano.
G. Mien.
H. Hmong.
I. Lao.
J. Turkish.
K. Hebrew.
L. French.
M. Polish.
N. Russian.
P. Portuguese.
Q. Italian.
R. Arabic.
S. Samoan.
T. Thai.
U. Farsi.
V. Vietnamese.