



HCP: Care Coordination Intake Interview



Client Information:

Last Name: First Name: Middle Name: Suffix: Gender:

Birth date:

Family Member Information:

Last Name: First Name: Middle Name: Suffix:

Relationship to Client:

Mother Friend
 Father Dept. of Human Services
 Grandparent Other
 Sibling Don't Know/Not Sure
 Other Relative Refused
 Step-Parent
 Foster-Parent
 Check if Legal Guardian

Language Spoken in Household (primary):

| | | |
|---|-------------------------------------|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Hmong | <input type="checkbox"/> Romanian |
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Indonesian | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Japanese | <input type="checkbox"/> Somali |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Karen | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Chinese (Mandarin) | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> French | <input type="checkbox"/> Laotian | <input type="checkbox"/> Other |
| <input type="checkbox"/> German | <input type="checkbox"/> Nepali | <input type="checkbox"/> Don't Know/Not Sure |
| <input type="checkbox"/> Hindi | <input type="checkbox"/> Polish | <input type="checkbox"/> Refused |
| | <input type="checkbox"/> Portuguese | |

Interpreter Needed: Yes No

Address Information:

| | | | |
|--|---------------------------|--|---------------------------|
| Primary Mailing Address: | | Secondary Mailing Address: | |
| Street: <input type="text"/> | | Street: <input type="text"/> | |
| City: <input type="text"/> | | City: <input type="text"/> | |
| State: <input type="text"/> | Zip: <input type="text"/> | State: <input type="text"/> | Zip: <input type="text"/> |
| County: <input type="text"/> | | County: <input type="text"/> | |
| Additional Information: <input type="text"/> | | Additional Information: <input type="text"/> | |

Contact Information:

Phone: (____) _____ - _____ Type: _____ Check if preferred

(____) _____ - _____ Type: _____ Check if preferred

E-Mail: _____@_____ Check if preferred



1a. Do you have a place where you regularly take your [child/youth] for health care? *[Talking point: a place other than the hospital emergency room or urgent care]*

- Yes
- No
- Don't Know/Not Sure
- Refused

1b. Do you have a place where you regularly take your [child/youth] for dental care?

- Yes
- No
- Don't Know/Not Sure
- Refused
- N/A – No teeth have erupted

2. If your [child/youth] needed to see a specialist *or medical provider*, was seeing a provider a problem for any reason?

- Yes
- No
- Don't Know/Not Sure
- Refused

3. In your opinion, how is the overall communication and working relationships between all of the people who provide medical care and services to your child/youth?

- Excellent
- Good
- Fair
- Poor
- Don't Know/Not Sure
- Refused

4. In your opinion, are you included in decisions made about [child/youth]'s health care?

- Always
- Sometimes
- Never
- Don't Know/Not Sure
- Refused

5a. During the past 6 months, has [child/youth] gone to a hospital emergency room?

- Yes
- No
- Don't Know/Not Sure
- Refused

b. If yes, how many times in the past 6 months? # _____

c. How many times was [he/she] admitted to the hospital? # _____



6. Does [child/youth] currently have any public or private health insurance?

- Yes
- No [skip to question 9]
- Don't Know/Not Sure [skip to question 9]
- Refused [skip to question 9]

7a. Insurance type (select as many as apply)

- | | |
|--|--|
| <input type="checkbox"/> Medicaid → | If Medicaid, select only one: |
| <input type="checkbox"/> CHP+ | <input type="checkbox"/> SSI |
| <input type="checkbox"/> Private Insurance | <input type="checkbox"/> Waiver |
| <input type="checkbox"/> Tricare | <input type="checkbox"/> HMO |
| <input type="checkbox"/> Other, _____ | <input type="checkbox"/> Straight |
| <input type="checkbox"/> Don't Know/Not Sure | <input type="checkbox"/> Medicaid Buy-in |
| <input type="checkbox"/> Refused | |

b. Is the child enrolled in a RCCO?

- Yes
- No
- Don't Know/Not Sure
- Refused

8. Does [child/youth]'s health insurance pay for all of the health services [he/she] needs?

- Yes [skip to question 10]
- No
- Don't Know/Not Sure
- Refused

9. Does [child/youth] use any assistance, discount, or charitable programs that help pay for the services [he/she] currently needs?

- Yes
- No
- Don't Know/Not Sure
- Refused

10. What other supports or services do you need to manage your [child/youth]'s needs? None

- | | | |
|--|---|--|
| <input type="checkbox"/> Adult Education | <input type="checkbox"/> Home Health Services | <input type="checkbox"/> Primary Care/Medical Home |
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Hospital – Children's Hospital | <input type="checkbox"/> RCCO |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Hospital – Other | <input type="checkbox"/> Recreational Activities |
| <input type="checkbox"/> Community Services | <input type="checkbox"/> Housing | <input type="checkbox"/> Referral to Other County/Agency |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Insurance | <input type="checkbox"/> Respite |
| <input type="checkbox"/> Developmental Screening | <input type="checkbox"/> Legal Issues | <input type="checkbox"/> School |
| <input type="checkbox"/> Early Intervention | <input type="checkbox"/> Medical Provider – Specialty | <input type="checkbox"/> Specialty Care |
| <input type="checkbox"/> Emotional Support | <input type="checkbox"/> Medical Supplies | <input type="checkbox"/> Support Group Services – All |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Medication | <input type="checkbox"/> Therapy – Occupational |
| <input type="checkbox"/> Family Leadership | <input type="checkbox"/> Mental/Behavioral Health | <input type="checkbox"/> Therapy – Physical |
| <input type="checkbox"/> Financial Assistance | <input type="checkbox"/> Nutrition/Dietary | <input type="checkbox"/> Therapy – Speech |
| <input type="checkbox"/> HCP Care Coordination | <input type="checkbox"/> Other Public Health Services | <input type="checkbox"/> Transition |
| <input type="checkbox"/> HCP Specialty Clinic | <input type="checkbox"/> Parent Education | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Head Start | <input type="checkbox"/> Parent Support | <input type="checkbox"/> Vision |
| | | <input type="checkbox"/> Other, _____ |



11. Has the family/referral source indicated a need for support in any of the following areas? [Talking point: In your professional experience]

- Yes No

If Yes, check the appropriate box(s) below:

- Adult Education, Home Health Services, Primary Care/Medical Home, Audiological, Hospital - Children's Hospital, RCCO, Child Care, Hospital - Other, Recreational Activities, Community Services, Housing, Referral to Other County/Agency, Dental, Insurance, Respite, Developmental Screening, Legal Issues, School, Early Intervention, Medical Provider - Specialty, Specialty Care, Emotional Support, Medical Supplies, Support Group Services - All, Employment, Medication, Therapy - Occupational, Family Leadership, Mental/Behavioral Health, Therapy - Physical, Financial Assistance, Nutrition/Dietary, Therapy - Speech, HCP Care Coordination, Other Public Health Services, Transition, HCP Specialty Clinic, Parent Education, Transportation, Head Start, Parent Support, Vision, Other, _____

12. Is anybody else providing care coordination services for [child/youth] at this time?

- Yes, No [skip to question 14], Don't Know/Not Sure, Refused

If yes, ask:

Who else is providing care coordination? (select as many as apply)

- Community Centered Board, Early Intervention/Board of Community Education Services (BOCES), Family Voices Colorado, Friend, Hospital, Medical Provider, Other Local Public Health Agency, Private Agency, RCCO, School, Self or Family Member, Other Community Partner, Don't Know/Not Sure, Refused



13. Is the current amount of care coordination [child/youth] is receiving enough to meet most or all of your family's needs?

- Yes
- No
- Don't Know/Not Sure
- Refused

14. Has any care provider talked with you and [your youth] about [his/her] needs as [he/she] becomes an adult? (ages 14-21 only)

- Yes
- No
- Don't Know/Not Sure
- Refused
- N/A (child is not of qualifying age)

15. Has anyone discussed with you and [your youth] how to obtain or keep some type of health insurance coverage as [he/she] becomes an adult? (ages 14-21 only)

- Yes
- No
- Don't Know/Not Sure
- Refused
- N/A (child is not of qualifying age)

16. During the past 6 months, about how many days did you or other household members, miss work because of your child/youth's special needs?

- # _____
- Don't Know/Not Sure
 - Refused
 - N/A (parent unable to work due to child's needs)

17a. Does [child/youth] need HCP Care Coordination services?

- Yes
- No
- Don't Know/Not Sure
- Refused

b. If yes, what setting do you prefer when meeting and/or working with your HCP Care Coordinator?

- By Phone
- In the Care Coordinator's Office
- In your Home
- By E-mail



HCP: Care Coordination Intake Interview



Office Information:

| | |
|--|---|
| Interviewer Name & Title: Date Interview Completed: | Intake Interview – Method of Contact: <input type="checkbox"/> E-mail <input type="checkbox"/> Phone <input type="checkbox"/> Home visit <input type="checkbox"/> Other, _____ <input type="checkbox"/> Office visit |
|--|---|

| | |
|--|--|
| Referral Taken By (Name & Title): Date of Referral: | Referral Source: Name: Phone: Fax: E-mail: |
|--|--|

Referral Source: (select as many as apply)

| | | |
|--|---|---|
| <input type="checkbox"/> 211 | <input type="checkbox"/> Friend | <input type="checkbox"/> Public Health Department |
| <input type="checkbox"/> BIAC | <input type="checkbox"/> HCP Specialty Clinic | <input type="checkbox"/> School |
| <input type="checkbox"/> Brochure | <input type="checkbox"/> Healthy Communities | <input type="checkbox"/> Specialty Provider |
| <input type="checkbox"/> Board of Community Education Services (BOCES) | <input type="checkbox"/> Hospital – Children’s Hospital | <input type="checkbox"/> Support Group Services |
| <input type="checkbox"/> CICP | <input type="checkbox"/> Hospital - Other | <input type="checkbox"/> Transfer from another HCP county |
| <input type="checkbox"/> CHP+ | <input type="checkbox"/> Human Services | <input type="checkbox"/> Website – CDPHE |
| <input type="checkbox"/> Community Center Boards | <input type="checkbox"/> Individual Services Support Team | <input type="checkbox"/> Website – LPHA |
| <input type="checkbox"/> Community Partner | <input type="checkbox"/> Medical Provider – Clinic | <input type="checkbox"/> Website – Other |
| <input type="checkbox"/> CRCSN Notification | <input type="checkbox"/> Medical Provider – Primary | <input type="checkbox"/> Work |
| <input type="checkbox"/> Family Member | <input type="checkbox"/> Medical Provider – Specialty | <input type="checkbox"/> Don’t Know/Not Sure |
| <input type="checkbox"/> Family Voices | <input type="checkbox"/> Medical Provider - Other | <input type="checkbox"/> Refused |
| | <input type="checkbox"/> Other Public Health Program | <input type="checkbox"/> Didn’t Ask |
| | | <input type="checkbox"/> Other _____ |

Did this proceed from the ‘Information Only’ process? Yes No
 Intake Interview stopped before completed? Yes No