

# INTAKE INTERVIEW

**HCP** A program for children & youth  
with special health care needs



## 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:	
<input type="checkbox"/> Mother	<input type="checkbox"/> Self
<input type="checkbox"/> Father	<input type="checkbox"/> Foster-Parent
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Friend
<input type="checkbox"/> Sibling	<input type="checkbox"/> Dept. of Human Services
<input type="checkbox"/> Other Relative	<input type="checkbox"/> Other, _____
<input type="checkbox"/> Step-Parent	
<input type="checkbox"/> Check if Legal Guardian	

Language Spoken in Household (primary):		
<input type="checkbox"/> English	<input type="checkbox"/> Hmong	<input type="checkbox"/> Portuguese
<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Indonesian	<input type="checkbox"/> Romanian
<input type="checkbox"/> Arabic	<input type="checkbox"/> Japanese	<input type="checkbox"/> Russian
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Karen	<input type="checkbox"/> Somali
<input type="checkbox"/> Chinese (Mandarin)	<input type="checkbox"/> Korean	<input type="checkbox"/> Spanish
<input type="checkbox"/> French	<input type="checkbox"/> Laotian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> German	<input type="checkbox"/> Nepali	<input type="checkbox"/> Other, _____
<input type="checkbox"/> Hindi	<input type="checkbox"/> Polish	
Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No		

## Address Information:

Primary Mailing Address:

Secondary Mailing Address:

Street:		Street:	
City:		City:	
State:	Zip:	State:	Zip:
County:		County:	
Additional Information:		Additional Information:	

## Contact Information:

Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Type: \_\_\_\_\_  Check if preferred

Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Type: \_\_\_\_\_  Check if preferred

E-Mail: \_\_\_\_\_@\_\_\_\_\_  Check if preferred

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Health & Environment

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

[Talking point: a place other than the hospital emergency room or urgent care]

- Yes
- No
- Refused

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

- Yes
- No
- Refused
- N/A – No teeth have erupted [below the age of 1]

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

- Yes
- No
- 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 your [child/youth]'s care?

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

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

- Yes
- No
- Refused

5b. If yes, how many times in the past 6 months? # \_\_\_\_\_

5c. How many times was [he/she] admitted to the hospital? # \_\_\_\_\_

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

- Yes
- No [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"/> Refused           | <input type="checkbox"/> Medicaid Buy-in |

7b. Is the [child/youth] enrolled in a RCCO/RAE?

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

8. Does your [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 your [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?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Adult Education         | <input type="checkbox"/> Home Health Services           | <input type="checkbox"/> None                            |
| <input type="checkbox"/> Audiology               | <input type="checkbox"/> Hospital – Children's Hospital | <input type="checkbox"/> Primary Care/Medical Home       |
| <input type="checkbox"/> Child Care              | <input type="checkbox"/> Hospital – Other               | <input type="checkbox"/> RCCO/RAE                        |
| <input type="checkbox"/> Community Services      | <input type="checkbox"/> Housing                        | <input type="checkbox"/> Recreational Activities         |
| <input type="checkbox"/> Dental                  | <input type="checkbox"/> Insurance                      | <input type="checkbox"/> Referral to other county/agency |
| <input type="checkbox"/> Developmental Screening | <input type="checkbox"/> Legal Issues                   | <input type="checkbox"/> Respite                         |
| <input type="checkbox"/> Early Intervention      | <input type="checkbox"/> Medical Provider – Specialty   | <input type="checkbox"/> School                          |
| <input type="checkbox"/> Emotional Support       | <input type="checkbox"/> Medical Supplies               | <input type="checkbox"/> Specialty Care                  |
| <input type="checkbox"/> Employment              | <input type="checkbox"/> Medication                     | <input type="checkbox"/> Support Group Services – All    |
| <input type="checkbox"/> Family Leadership       | <input type="checkbox"/> Mental/Behavioral Health       | <input type="checkbox"/> Therapy – Occupational          |
| <input type="checkbox"/> Financial Assistance    | <input type="checkbox"/> Nutrition/Dietary              | <input type="checkbox"/> Therapy – Physical              |
| <input type="checkbox"/> HCP Care Coordination   | <input type="checkbox"/> Other Public Health Services   | <input type="checkbox"/> Therapy – Speech                |
| <input type="checkbox"/> HCP Specialty Clinic    | <input type="checkbox"/> Parent Education               | <input type="checkbox"/> Transition                      |
| <input type="checkbox"/> Head Start              | <input type="checkbox"/> Parent Support                 | <input type="checkbox"/> Transportation                  |
|  |   | <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:

- |  |   |  |
|--|---|--|
| <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/RAE                        |
| <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, _____                    |

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

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

If yes, 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/RAE  
 School  
 Self or Family Member  
 Other Community Partner  
 Refused

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13. Is the current amount of care coordination your [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)

[Examples: waitlists for adult services, obtaining state ID, SSI application, registering to vote, post-secondary education, career pat, etc.]

- Yes
- No
- Don't Know / Not Sure [youth directs own care; parent/guardian not included]
- 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 [youth directs own care; parent/guardian not included]
- 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/youth]'s needs
  - N/A – parent unemployed; unrelated to [child/youth]'s needs

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

- Yes
- No

17b. 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

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

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

Referral Source: (select as many as apply)

<input type="checkbox"/> 211	<input type="checkbox"/> Healthy Communities	<input type="checkbox"/> School
<input type="checkbox"/> BIAC	<input type="checkbox"/> Hospital – Children’s Hospital	<input type="checkbox"/> Specialty Provider (i.e. OT, PT, speech)
<input type="checkbox"/> Brochure	<input type="checkbox"/> Hospital – Other	<input type="checkbox"/> Support Group Services
<input type="checkbox"/> Board of Community Education Services (BOCES)	<input type="checkbox"/> Human Services	<input type="checkbox"/> Transfer from another HCP county
<input type="checkbox"/> CICIP	<input type="checkbox"/> Individual Services Support Team	<input type="checkbox"/> Website – CDPHE
<input type="checkbox"/> CHP+	<input type="checkbox"/> Medical Provider – Primary	<input type="checkbox"/> Website – LPHA
<input type="checkbox"/> Community Center Boards	<input type="checkbox"/> Medical Provider – Specialty	<input type="checkbox"/> Website – Other
<input type="checkbox"/> Community Partner	<input type="checkbox"/> Mental / Behavioral Health	<input type="checkbox"/> WIC
<input type="checkbox"/> Family Member	<input type="checkbox"/> NICU	<input type="checkbox"/> Work
<input type="checkbox"/> Family Voices	<input type="checkbox"/> Other Public Health Program	<input type="checkbox"/> Refused
<input type="checkbox"/> Friend	<input type="checkbox"/> Previous HCP Care Coordination Client	<input type="checkbox"/> Didn't Ask
<input type="checkbox"/> HCP Specialty Clinic	<input type="checkbox"/> Public Health Department	<input type="checkbox"/> Other, _____
	<input type="checkbox"/> RCCO/RAE	

Did the family refuse to complete the intake interview?  Yes  No  
*[Taking Point: Only select "yes" if the family does not intend to continue with Care Coordination services.]*