|  |  |  |  |
| --- | --- | --- | --- |
| **1 unit/encounter** |  |  | **County Health Department** |

**Babies First/CaCoon Targeted Case Management (TCM) Assessment**

|  |
| --- |
|  |

**TCM CARE ELIGIBILITY:** (all must be checked to bill)

|  |
| --- |
| The child has at least one Babies First!/CaCoon risk factor and is enrolled in B1st, CaCoon or NFP |
| The child has not reached 5th birthday (Babies First!/NFP) or 21st birthday (CaCoon) |
| The child is enrolled in Medicaid at the time of the TCM visit |
|  |

Other services child/family is receiving:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| EI | DHS – Child Welfare | | Developmental Disabilities | | Other TCM program (specify): | |  |
| Caseworker/Caregiver | |  | |  | Phone number: |  | |

*(Documentation of service coordination required for billing)*

|  |
| --- |
|  |

The child’s/family’s strengths that can be leveraged to support TCM plan:

Support System (current natural and community supports):

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Family Assessment:** | | **Need Help** | | **No Help Needed** | | **Family Assessment** | | **Need Help** | | **No Help Needed** | |
| Dental care | | |  |  | Accessing quality childcare | | | |  |  |
| Early education services | | |  |  | Advocating for child | | | |  |  |
| Health Ins/OHP: maintaining coverage | | |  |  | Clothing and basic supplies | | | |  |  |
| Immunizations | | |  |  | Establishing & maintaining stable income | | | |  |  |
| Medical specialty care | | |  |  | Maintaining stable housing | | | |  |  |
| Special therapies like PT/OT/speech | | |  |  | Scheduling & keeping appointments | | | |  |  |
| Social security income | | |  |  | Securing adequate food | | | |  |  |
| Well child care | | |  |  | Transportation | | | |  |  |
| WIC | | |  |  | Relief Nursery | | | |  |  |
| Other |  | |  |  | Other | |  | |  |  |

|  |  |  |
| --- | --- | --- |
| The child’s family **does not need** assistance accessing and/or utilizing needed services | | |
|  | Family is acting as an effective advocate for their child | |
|  | Knowledgeable of services and how to access services | |
|  | History of being able to adequately access and utilize needed services | |
|  | Adequate social supports | |
|  | TCM Case Manager already in place and meeting needs (see above for details) | |
|  | Other: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| The child’s family **does need** assistance accessing and/or utilizing needed services | | | |
|  | Inability to fill out paperwork because of language barrier, low literacy, etc. | | |
|  | Inability to secure basic child needs (food, clothing, shelter, etc.) | | |
|  | Family health needs impacting the child’s ability to access and utilize needed services | | |
|  | Lack of awareness regarding health and human resources available in the community | | |
|  | History of not following through with accessing or utilizing needed services | | |
|  | Family with limited advocacy skills |  | |
|  | Cultural/language barriers to services | Instability of finances/housing/environment | |
|  | Inadequate caregiver literacy | Lack of awareness regarding preventive health care services | |
|  | Inadequate caregiver health literacy | Inadequate support system | |
|  | Transportation difficulties | Other: (specify) |  |
| **Assessment notes:** | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TCM RN Case Manager Signature:** | |  |  | **Date:** |  |
| **Client name:** |  | |  | **DOB:** |  |

Rev/12.2011

|  |
| --- |
| **TCM SERVICE PLAN & GOALS** |

|  |  |
| --- | --- |
| **Date of Next TCM Plan Review:** |  |

|  |
| --- |
|  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **GOALS:** | | | | | | |
| Client-identified top two priorities/goals: | | | | |  |
| 1. |  |  | 2. |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Agreed upon goals (Case Manager and Family)** | | **Target date for completion:** | | |
| Demonstrate ability to identify and independently access needed health services by  (WCC Immunizations, vision, hearing and dental) | | |  |
| Demonstrate ability to identify and independently access needed early learning services or quality childcare b  (Early Intervention, Special Education, Early Literacy, Head Start and EHS) | | |  |
| Demonstrate ability to identify and independently access needed social services by  (transportation, support system, basic needs, housing, food and SSI) | | |  |
| Other (specify) | |  |  |

|  |
| --- |
|  |

|  |  |  |
| --- | --- | --- |
| **Planned ACTIVITIES/INTERVENTIONS planned to achieve goal(s):** | | |
| Ongoing identification of barriers | |
| Ongoing identification of strengths | |
| Assist family in increasing knowledge of community resources | |
| Assist family in working with needed services and agencies | |
| Assist family in completing paperwork for: | |
| Assist family to gain skills to become an effective advocate | |
| Assist family to expand support system | |
| Problem solve with family to obtain transportation to needed services | |
| Motivate family to adhere to the schedules for treatment and services | |
| Other (specify): |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Planned REFERRAL/LINKING:** (check all that apply) | | | | | | | | | | | | | | | |
| Assist family to schedule and keep appointments | | | | | | | | | | | | | | |
| Dental | Child Care | Early Intervention/ECSE | | | | | | Special Education | | | | OHP/Health Insurance | | |
| Specialty Health Care Provider | | | | Transportation | | | WIC | | | | Immunizations | | | |
| Basic Needs: food, clothing, shelter (specify) | | | | | |  | | | | | | | | |
| Primary Health Care Provider | | |  | | Other (specify) | | | |  | Other (specify) | | |  | Other (specify) |

|  |
| --- |
|  |

|  |  |  |
| --- | --- | --- |
| **Planned MONITORING:** | | |
| Monitor the family’s ability to access and utilize needed resources | |
| Monitor for commitment to TCM Plan | |
| Monitor progress toward goals | |
| Other: |  |

|  |
| --- |
|  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **NOTES:** | | | | | | |
| RN Case Manager Signature: | | | |  |  | Date: |  | |
| Home Visitor Signature: | | |  | | Date: |  | |
| **Client Name:** | |  | | | **DOB:** |  | |

Rev/12.2011