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| **[ ]** **1 unit/encounter** |  |  | **County Health Department** |

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

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

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| [ ]  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:

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

*(Documentation of service coordination required for billing)*

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

Support System (current natural and community supports):

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| --- | --- | --- | --- | --- | --- |
| **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 |       |  |  |

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| [ ]  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: |       |

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| [ ]  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:** |

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

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|  **TCM SERVICE PLAN & GOALS** |

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

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

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|  **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) |  |       |

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|  **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): |       |

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|  **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)      |

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

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

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