JUST Health Transition of Care (TOC) Assessment/Plan/HRA (APHRA)

CNA Required for All JUST Health TOC Members

TOC Plan Follow-Up Required for Items in **GREEN**

Member's Name (First, Middle, Last)	**Member's Medicaid ID**	**Date**

Projected Release Date	**Actual Release Date**	**Date of MCO Notification of Release**

Member's Address	**City**	**State**	**Zip**

Home Phone	**Cell Phone**	**Other Phone**

Emergency Contact Name/Phone	**Date of Birth**

Assessment Method	**Demographics Verified?**
☐Telephonic ☐In-person ☐Other	☐Yes ☐No

	Question	**Response**
1.	What sex were you assigned at birth, on your original birth certificate?	☐ Male ☐ Female ☐ X or intersex ☐ Decline/prefer not to answer.
2.	What is your current gender?	☐ Male ☐ Female ☐ Transgender Man ☐ Transgender Woman ☐ Non-binary ☐ Other – please specify ______________________________ ☐ Decline/prefer not to answer. *We ask this for reporting only. Your response will not have an effect on your benefits.*
3.	What is your Sexual Identity?	☐ Gay or lesbian ☐ Straight, that is not gay or lesbian ☐ Bisexual ☐ Other – please specify ______________________________ ☐ Decline/prefer not to answer. *We ask this for reporting only. Your response will not have an effect on your benefits.*
4.	Do you have a language need other than English? Do you need translation services? Please describe:	☐Yes ☐No ☐Yes ☐No
5.	Do you have any special preferences we should be aware of?	☐Cultural preference ☐Hearing Impairment ☐Literacy ☐Religion/Spiritual needs or preferences ☐Visual Impairment ☐None

		☐Other (describe):
6.	What is your main health concern right now?	
7.	Do you have any current or past physical and/or behavioral health conditions or diagnoses?	☐Behavioral health diagnosis ☐Comorbid conditions ☐ICF/MR/DD ☐High risk pregnancy ☐Transplant patient ☐Medically Fragile Waiver Program ☐Medically frail ☐Traumatic brain injury ☐Other acute or terminal disease: (if yes to any, add to TOC Plan Q1)
8.	Do you currently use tobacco and/or nicotine products? If yes, are you interested in receiving information on or participating in a tobacco cessation program? Do you have a history of using tobacco and/or nicotine products?	☐Yes ☐No ☐Yes ☐No (if yes, add to TOC Plan Q2) ☐Yes ☐No
9.	Compared to others your age, would you say your health is...?	☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor
10.	Do you have any pending physical health procedures or behavioral health appointments? Date of most recent physical examination or medical appointment:	☐Yes ☐No
11.	Do you need assistance in obtaining a phone?	☐Yes ☐No (if yes, add to TOC Plan Q3)
12.	Do you need assistance in finding a: PCP? BH Therapist? DME Provider? Optometrist? Dentist? Specialist (enter type):	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No (if yes to any, add to TOC Plan Q4)
13.	Have you visited the Emergency Room in the past 6 months? If yes, how many visits? Date(s) of ER visit(s): Reason for ER visit(s):	☐ Yes ☐No ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 or more
14.	Have you stayed overnight in the hospital in the past 6 months? If yes, how many times? If yes, were you readmitted within 30 days of discharge?	☐Yes ☐No ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 or more ☐Yes ☐No
15.	How many medicications are you currently taking?	☐1 ☐2 ☐3 ☐4 ☐5 ☐6
16.	Do you need assistance in obtaining your medications?	☐Yes ☐No (if yes, add to TOC Plan Q5)
17.	What is/will be your post-release living situation?	☐Homeless ☐Live alone ☐Group home ☐Shelter ☐Live with other family ☐Live with others unrelated ☐Live with spouse

		☐Assisted living facility ☐Out of state facility ☐Out of home placement ☐Dependent child in out of home placement ☐Nursing facility ☐Other (describe):
18.	Do you need assistance in obtaining housing?	☐Yes ☐No (if yes, add to TOC Plan Q6)
19.	Do you need assistance with 2 or more of the following? Is your need for assistance being met today?	☐Yes ☐No ☐Dressing ☐Bathing/grooming ☐Eating ☐Meal acquisition/preparation ☐Transfer ☐Mobility ☐Toileting ☐Bowel/bladder ☐Daily medication ☐Other: ☐Yes ☐No
20.	Do you need or are you interested in Long-Term Care services for these needs?	☐Yes ☐No (If yes, add to TOC Plan Q7)
21.	What is your current Medicaid eligibility status?	☐Active ☐Suspended (if suspended, add to TOC Plan Q8)
22.	Will you/do you have an income source upon release?	☐Yes ☐No (if no, add to TOC Plan Q9)
23.	Will you/do you have access to reliable transportation?	☐Yes ☐No (if no, add to TOC Plan Q10)
24.	Do you/will you have reliable employment?	☐Yes ☐No (if no, add to TOC Plan Q11)
25.	Do you have family and/or friends that you can talk with and who will provide you with support? Do you have connections in your community that will provide you with support?	☐Yes ☐No ☐Yes ☐No (if no to both questions, add to TOC Plan Q12)
26.	An advance 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 advance directive in place? Could I send you more information?	☐Living will ☐Advance directive (for medical care) ☐Advance directive (for psychiatric care) ☐No living will or advance directive in place ☐Declined discussion ☐Requested further information (if requested further info, add to TOC Plan Q13)
27.	Do you have any concerns for your safety?	☐Yes ☐No (if yes, add to TOC Plan Q14)
28.	Are you interested in receiving Care Coordination Services?	☐Yes ☐No
29.	What are your most important concerns today?	

TOC Plan

	Follow-Up Item	Follow-Up Action	Completion Target Date	30-60 Calendar Day Post CNA Follow-up Visit Update
1.	Diagnosis specific			
2.	Tobacco Cessation			
3.	Telephone			
4.	Provider			
5.	Medication			
6.	Housing			
7.	Community Benefits/ Long-Term Services			
8.	Medicaid Eligibility			
9.	Income Support			
10.	Transportation			
11.	Employment Services			
12.	Interpersonal Skills			
13.	Living Will/ Advance Directive			
14.	Safety			
15.	Other			

Care Coordination/Next Steps

Guidelines for Assessor explanation of Care Coordination:

- A care coordinator is your main point of contact for information about services covered by [MCO name].
- These services include medications, doctor's appointments, physical therapy, medical equipment, hospital visits, vision and dental services and transportation to medical appointments.
- Your care coordinator can help you find out if you qualify for Community Benefits. These benefits might include someone coming to your home to help you prepare meals or make home repairs that you need to stay safe.
- Your care coordinator will help you find extra care and services from providers or community programs that are not covered by [MCO name].
- Your care coordinator will work with you and those who care for you to create a care plan. A care plan can help you meet your health goals.
- There are two types of Care Coordination – Level 2 and Level 3. Level 2 is for people who need assistance with some of their health needs. Level 3 is for people with higher needs.
- Your care coordinator will visit you in-person to do a Comprehensive Needs Assessment, or CNA.
- The CNA will help find out what services you can receive.
- Your care coordinator will check in with you every month or every few months by telephone.
- Your care coordinator will visit you in your home at least once a year (when the COVID Public Health Emergency has ended).
- You can ask for a higher level of Care Coordination at any time.

Are you interested in receiving Care Coordination Services?	☐Yes ☐No (If yes, CNA required)