



Health Action Plan (HAP)



CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	UNKNOWN <input type="checkbox"/>	OTHER <input type="checkbox"/>	DATE OF BIRTH	PROVIDER ONE CLIENT ID
HEALTH HOME LEAD ORGANIZATION						HH LEAD ORGANIZATION PHONE	
DATE OF HAP: BEGIN		END		DATE OPTED IN		CARE COORDINATION ORGANIZATION	
CARE COORDINATOR'S NAME				CARE COORDINATOR'S PHONE			

REASON FOR CLOSURE OF THE HAP <input type="checkbox"/> Beneficiary Opted Out <input type="checkbox"/> Death <input type="checkbox"/> Move to a county that does not have Health Home services <input type="checkbox"/> No longer eligible	REASON FOR TRANSFER OF THE HAP <input type="checkbox"/> Client choice to change CCO or Lead Organization <input type="checkbox"/> Eligibility changed (change to/from FFS or MCO)
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CLIENT INTRODUCTION

CLIENT'S LONG TERM GOAL

DIAGNOSIS (PERTINENT TO HAP)

Initial / Annual HAP Required Screenings				Four Month Update Required Screenings				Eight Month Update Required Screenings			
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SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN	SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN	SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM		/		PAM		/		PAM		/	
CAM		/		CAM		/		CAM		/	
PPAM		/		PPAM		/		PPAM		/	
Katz ADL				Katz ADL				Katz ADL			
PHQ-9				PHQ-9				PHQ-9			
PSC-17				PSC-17				PSC-17			
BMI				BMI				BMI			

OPTIONAL SCREENING SCORES				OPTIONAL SCREENING SCORES				OPTIONAL SCREENING SCORES			
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SCREEN	DATE	SCORE		SCREEN	DATE	SCORE		SCREEN	DATE	SCORE	
DAST				DAST				DAST			
GAD-7				GAD-7				GAD-7			
AUDIT				AUDIT				AUDIT			
FALLS RISK				FALLS RISK				FALLS RISK			
PAIN			<input type="checkbox"/> FLACC <input type="checkbox"/> FACES <input type="checkbox"/> NUMERIC	PAIN			<input type="checkbox"/> FLACC <input type="checkbox"/> FACES <input type="checkbox"/> NUMERIC	PAIN			<input type="checkbox"/> FLACC <input type="checkbox"/> FACES <input type="checkbox"/> NUMERIC

ADDITIONAL COMMENTS	ADDITIONAL COMMENTS	ADDITIONAL COMMENTS
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