Attachment A

BexarCare

SB1165 Pilot Project

Identification of Children with Complex Special Health Care Needs (CCSHCN)
Bexar Service Delivery Area

THSteps Information and Outreach

QUESTION ASKED:
1. Does your child need services that you are having trouble finding?

Enrollment Broker Health Status Screening Tool

QUESTIONS PERTAINING TO CCSHCN:
7. Do you [enrollee] need regular medical care that should not be stopped (such as wheelchair, ventilator, feeding tube?
8. Do you [enrollee] need or use more medical care, mental health or educational services than most others your age?
9. Do medical or mental health problems limit your [enrollee] daily activities compared to most others your age (play, school, work)?

General Referral Forms

- Referral from any source (family, school, PCP, specialist, plan, etc.)
- Form will be included in the THSteps Periodic Due and Overdue letters beginning December 1999.
- Form will be provided to providers via the THSteps
- Form will be available via HHSC Web Site

OTHER

- THSteps Diagnosis Code Report for Targeted Outreach.
- Report from Health Plans on existing members in case management with the plan.

THSteps CMI Unit

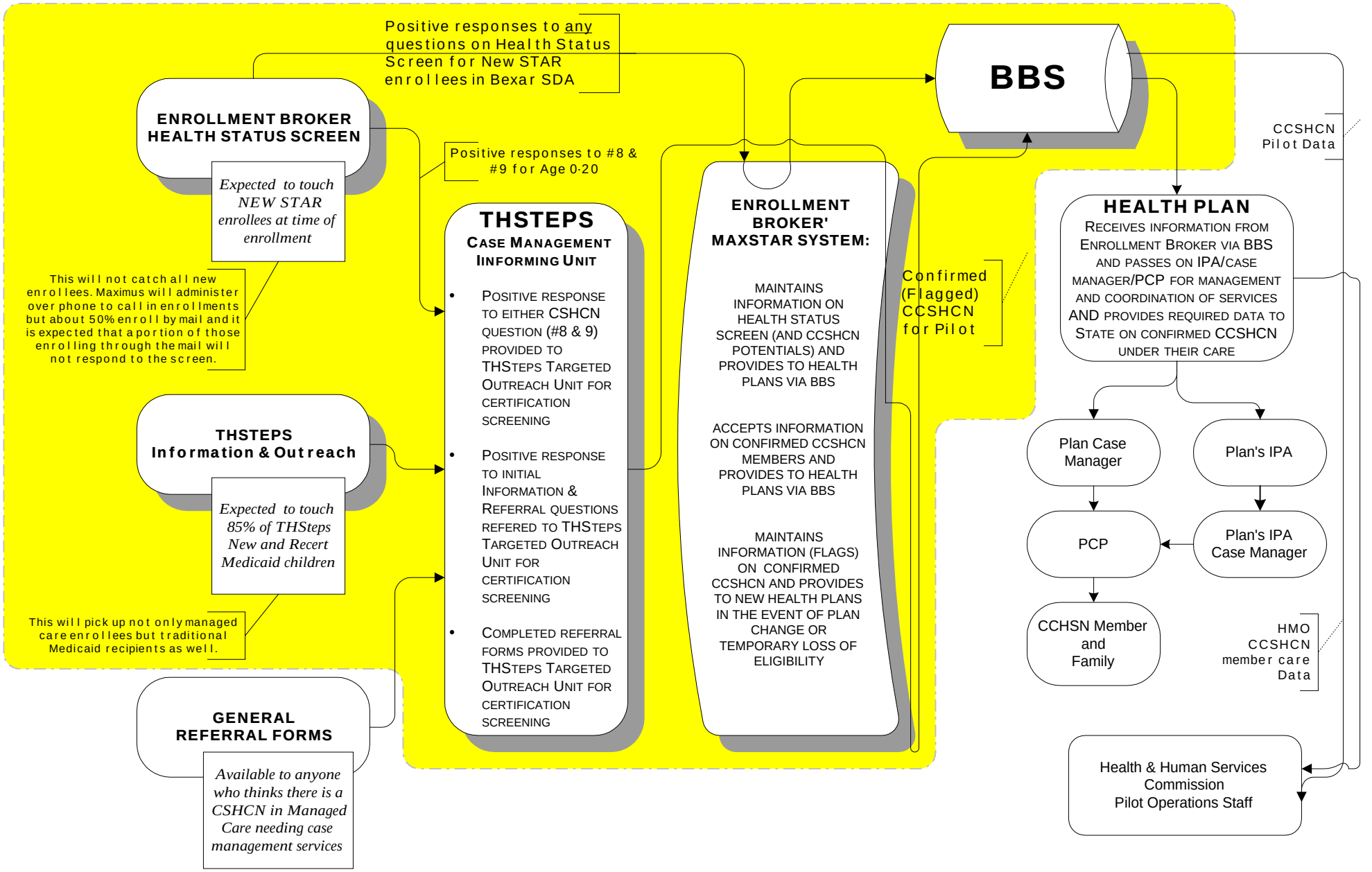
Identification Tool Admnistrator

Revised 10/21/99

Attachment B

Identification of Children with Complex Special Health Care Needs (CCSHCN) for SB1165 Pilot Project

November 1999



Attachment C

HEALTH SCREEN HOW IS YOUR HEALTH? MAXIMUS

Please circle the answer for each member in your household under each question.

GENERAL INFORMATION:	**ADDRESS:** _____ **PHONE:** _____			
	Name: _____ **Age:** _____ **Medicaid ID #:** _____	**Name:** _____ **Age:** _____ **Medicaid ID #:** _____	**Name:** _____ **Age:** _____ **Medicaid ID #:** _____	**Name:** _____ **Age:** _____ **Medicaid ID #:** _____
Do you [enrollee] need information in a special way because of problems with seeing, or hearing (Braille, large print, audio tape)?	**Yes No**	**Yes No**	**Yes No**	**Yes No**
Do you [enrollee] need information in another language because you don't speak English or Spanish?	**Yes No**	**Yes No**	**Yes No**	**Yes No**
Are you [or parent/guardian] a migrant worker.	**Yes No**	**Yes No**	**Yes No**	**Yes No**
Are you [enrollee] pregnant? If yes, what is the due date: _____	**Yes No**	**Yes No**	**Yes No**	**Yes No**
Have you [enrollee] been in the hospital or emergency room in the last 2 months?	**Yes No**	**Yes No**	**Yes No**	**Yes No**
Do you [enrollee] have any surgery scheduled in the next 4 weeks?	**Yes No**	**Yes No**	**Yes No**	**Yes No**
Do you [enrollee] need regular medical care that should not be stopped (*such as wheelchair, ventilator, feeding tube*)?	**Yes No**	**Yes No**	**Yes No**	**Yes No**
Do you [enrollee] need or use more medical care, mental health or educational services than most others your age?	**Yes No**	**Yes No**	**Yes No**	**Yes No**
Do medical or mental health problems limit your [enrollee] daily activities compared to most others your age (play, school, work)?	**Yes No**	**Yes No**	**Yes No**	**Yes No**
. Do you [enrollee] take three (3) or more prescription drugs every day?	**Yes No**	**Yes No**	**Yes No**	**Yes No**
. Have you [enrollee], or any family member, ever been told you had Diabetes?	**Yes No**	**Yes No**	**Yes No**	**Yes No**