Health & Welfare Form

Referred by:

☐ Alpha One   ☐ EIM

Date of Health and Welfare risk assessment

_____/_____/_____

What is the consumer's first name?

_____

What is the consumer's last name?

_____

Enter the consumer's Mecare ID number.

_____

Current Program:

☐ HB (Homeward Bound)
☐ HBC
☐ HCB
☐ ORC
☐ PDN
☐ CDPA

1. What triggered this review?

☐ Audit Process
☐ Home Visit
☐ Issue/Complaint
☐ Monthly Call

2. Health & Welfare Risk Assessment: Based on audit process, home visit observation, issue/complaint, phone call, is consumer's health and welfare at risk with current POC and supports in place?

☐ Yes. Explain risk in notes section and complete Section 3

☐ No. If No, go to Section 4 (do not add comments)

3. If Yes, identify steps to address risk:

☐ ADRC/AAA Referral (use notes to include referral date)

☐ APS Referral (use notes to include referral date)

☐ Crisis Intervention Referral (use notes to include referral date)

☐ Daily Living Supports (DLS) Referral (use notes to include referral date)

☐ Environmental Modification Referral (use notes to include referral date)

☐ Mental Health CM Referral/Linda (use notes to include referral date)

☐ POC Revision Referral (use notes to include referral date)

☐ Reassessment Referral (use notes to include referral date)

☐ N/A

Other Steps:

☐ Alternative Services Options Provided (use notes to describe options)

☐ Event Log Completed

☐ Other (use notes to describe steps)

☐ OADS Contacted

☐ Primary Care Physician Contacted

☐ Police Contacted

☐ Referral to Skilled Provider

☐ Staffing Search

☐ Safety Issues - B/U plan and possible termination discussed

☐ N/A

4. Unmet Need Determination: Based on audit process, home visit observation, case conference or phone call, is there an unmet need identified that is not currently addressed in POC?

☐ Yes (Complete Sections 4A and 4B then 5,6,7)

☐ No, but still unmet need (Complete Sections 4A & 4B and 5-7)

☐ No Unmet Needs Identified (Skip to Sections 5,6,7)

4A. Unmet Need Due to (Choose all that apply):

☐ Change in Health Condition

☐ Change in or Need of Informal Support

☐ Change in Other Formal Support (Medicare/MH/Therapies, etc)

☐ Consumer Choice/Behavior

☐ Environmental Challenges

☐ Needs Not Addressed Adequately in POC

☐ POC Not Fully Staffed

☐ Transportation Not Available

☐ Other (Explain in notes)

☐ N/A

4B. **Requires Follow-Up (Choose all that apply):**

- [ ] ADRC/AAA
- [ ] Call Primary Care Physician
- [ ] Call Skilled Provider
- [ ] Call to Other Resources (Explain in notes)
- [ ] Environmental Assessment/ILA
- [ ] Environmental Mod Referral (List date in notes)
- [ ] Home Visit
- [ ] MDT Conducted
- [ ] Need cannot be met in the community
- [ ] No, Action Already Taken (Add steps in notes)
- [ ] POC Revision Referral (List date in notes)
- [ ] Reassessment Referral (List date in notes)
- [ ] Other (Explain in notes)
- [ ] N/A

5. **Name and Title of Person Completing H and W:**

_____

_____

_____

_____

Date Health and Welfare form completed

_____/_____/_____

6. **Result of Action Steps/Record Review Outcome (Choose all that apply):**

- [ ] N/A
- [ ] APS Opened (list date in notes)
- [ ] APS Did not open or closed case
- [ ] Consumer Hospitalized
- [ ] Home Visit Completed
- [ ] Opened to Skilled Services
- [ ] Opened to AAA (list services in notes)
- [ ] Other (explain in notes)
- [ ] POC Change
- [ ] Program Change (list in notes)
- [ ] Program Terminated - Institutionalized
- [ ] Program Terminated - Internal
- [ ] Program Terminated - OADS
- [ ] Waiting for Outcome

Date of result of action or review completed

_____/_____/_____

7. Summary/Notes