



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)
---	--	---

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			
--	--	--	--	---------------------------------------	--	--	--	--	--	--	--

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			
---------------------------	--	--	--	---------------------------	--	--	--	---------------------------	--	--	--

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
---------------------	---------------------	---------------------



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			

Initial / Annual HAP			Four Month Update			Eight Month Update		
Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue			Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue			Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue		
START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS



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				

Initial / Annual HAP			Four Month Update			Eight Month Update		
Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue			Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue			Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue		
START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS



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				

Initial / Annual HAP			Four Month Update			Eight Month Update		
Short Term Goal: Goal Start Date: Goal End Date: Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue			Short Term Goal: Goal Start Date: Goal End Date: Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue			Short Term Goal: Goal Start Date: Goal End Date: Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue		
START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS



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			

Initial / Annual HAP			Four Month Update			Eight Month Update		
Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue			Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue			Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue		
START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS



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			

Initial / Annual HAP			Four Month Update			Eight Month Update		
Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue			Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue			Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue		
START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS



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			

Initial / Annual HAP			Four Month Update			Eight Month Update		
Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue			Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue			Short Term Goal: Goal Start Date: _____ Goal End Date: _____ Outcome: <input type="checkbox"/> Completed <input type="checkbox"/> No longer pertinent – life or health change <input type="checkbox"/> Revised <input type="checkbox"/> Client request to discontinue		
START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS	START DATE	COMPLETION DATE	ACTION STEPS