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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| chart review tool | | | | | | | | | | | | | | | |
| Michigan Department of Health and Human Services | | | | | | | | | | | | | | | |
| Maternal Infant Health Program | | | | | | | | | | | | | | | |
| **BENEFICIARY** | | | | | | | | | | | | | | | |
| Name | | | | | | | | Date First Contacted or Visited | | | | | | | |
|  | | | | | | | |  | | | | | | | |
| **FORMS CHECKLIST (5700/5701)** | | | | | | | | | | | | | | | |
| Beneficiary Name Present | | | | | Date Referral to MIHP Received | | | | | | | Contacted w/in Appropriate Days\* | | | |
| Yes | | No | | |  | | | | | | | Yes | | No | |
| Alterations Done Inappropriately | | | | | | | | | | | | | | | |
| Yes | No | | NA | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **CONTACT LOG (5649)** | | | | | | | | | | | | | | | |
| MIHP Agency Name Present | | | | | Beneficiary Name Present | | | | | | | Alterations Done Inappropriately | | | |
| Yes | | No (Not Required) | | | Yes | | No | | | | | Yes | | No | NA |
| Notes | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **CONSENT TO PARTICIPATE (5647/5652)** | | | | | | | | | | | | | | | |
| MIHP Agency Name Present | | | | | Consent to Participate in Risk Identifier Checked (one box) | | | | | | | | | | |
| Yes | | No | | | Yes | | No | | | | | | | | |
| Consent to Participate in MIHP Checked (one box) | | | | | | | | Beneficiary/Legal Representative Signature Section Complete and Accurate\*\* | | | | | | | |
| Yes | | No | | | | | | Yes | No | | | | | | |
| Professional Signature Section Complete and Accurate\*\* | | | | | | | | Date of Beneficiary/Legal Representative Signature | | | | | | | |
| Yes | | No | | | | | |  | | | | | | | |
| Dated on or before RI | | | | | | | | Alterations Done Incorrectly | | | | | | | |
| Yes | | No | | | | | | Yes | No | | NA | | | | |
| Notes | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **CONSENT TO RELEASE PHI (5653/5645)** | | | | | | | | | | | | | | | |
| MIHP Agency Name Present | | | | All Necessary Dates & Initials | | | | | | Consent to Release PHI Checked (one box) | | | | | |
| Yes | | No | | Yes | | No | | | | Yes | | | No | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Beneficiary/Legal Representative Signature Section Complete and Accurate\*\* | | | | | | | | | | | | | | | | | | | | | | |
| Yes | No | | | | | | | | | | | | | | | | | | | | | |
| Professional Signature Section Complete and Accurate\*\* | | | | | | | | | Consented to Communication w/Medical Provider re: Infant | | | | | | | | | | | | | |
| Yes | No | | | | | | | | Yes | | No | | | | | | | | | | | |
| Consented to Communication w/Medical Provider re: Caregiver | | | | | | | | | | | | | Alterations Done Incorrectly | | | | | | | | | |
| Yes | No  NA | | | | | | | | | | | | Yes | | | | No | | NA | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **RISK IDENTIFIER** | | | | | | | | | | | | | | | | | | | | | | |
| Present | | | | | | RI Screening Date | | | | | | | | Profession Conducted RI | | | | | | | | |
| Yes | | No | | | |  | | | | | | | | RN | | LSW | | | | Neither | | |
| Completed Prior to any Professional Visit | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | No | | | | | | | | | | | | | | | | | | | | |
| If RI not Completed Prior to any Professional Visit, Emergency Documented on PVPN or Contact Log | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | No  NA | | | | | | | | | | | | | | | | | | | | |
| Alterations Done Incorrectly | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | No | | NA | | | | | | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **RISK IDENTIFIER SCORESHEET** | | | | | | | | | | | | | | | | | | | | | | |
| Risk Levels Marked | | | | | If no Risk Identified, Exception Approval Present | | | | | | | | | | Alterations Done Incorrectly | | | | | | | |
| Yes | | | No | | Yes | | No | NA | | | | | | | Yes | | | No | | | | NA |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **PLAN OF CARE, PART 1 [5637/5642]** | | | | | | | | | | | | | | | | | | | | | | |
| Beneficiary Name Present | | | | | | | | | | Activity #5 (one box checked) | | | | | | | | | | | | |
| Yes | | | No | | | | | | | Yes | | No | | | | | | | | | | |
| Activity #11 (one box checked) | | | | | | | | | | Activity #14 Entry (one or more item listed) | | | | | | | | | | | | |
| Yes | | | No | | | | | | | Yes | | No | | | | | | | | | | |
| Professional Signature Section Complete and Accurate\*\* | | | | | | | | | | | | | | | Alterations Done Incorrectly | | | | | | | |
| Yes | | | No | | | | | | | | | | | | Yes | | | No | | | NA | |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
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| **PLAN OF CARE, PART 2 [5690-5696/5630-5632, 5665, 5665-5667, 5669, 5670, 5672-5675]** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| POC 2 Domains from RI Scoresheet Present | | | | | | | | | | | | | | | Unknown Risk Levels from RI Scoresheet are Marked Highest Possible Level on POC 2 | | | | | | | | | | | | | | |
| Yes | | | No | | | | | | | | | | | | Yes | | | No | | | | NA | | | | | | | |
| If Risk Level Changed, New Intervention Level Checked | | | | | | | | | | | | | | | If Risk Level Changed, Date of Change Documented | | | | | | | | | | | | | | |
| Yes | | | No | | | | | NA | | | | | | | Yes | | | No | | | | NA | | | | | | | |
| If Domains Added Based on Professional Judgement, Date of Addition Present | | | | | | | | | | | | | | | | | | | | | | | | Alterations Done Incorrectly | | | | | |
| Yes | | | No | | | | | NA | | | | | | | | | | | | | | | | Yes | | | No | | NA |
| Notes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PLAN OF CARE, PART 3 [5697/5676]** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Beneficiary Name Present | | | | | | | | | | Case Manager Name Present | | | | | | | | Reassigned Case Manager Name Present | | | | | | | | | | | |
| Yes | | | No | | | | | | | Yes | | No | | | | | | Yes | | | | | No | | NA | | | | |
| RN and LSW Signatures within 10 Business Days | | | | | | | | | | | | | | | Both Professionals Signatures are Dated Prior to any Professional Visit | | | | | | | | | | | | | | |
| Yes | | | No | | | | | | | | | | | | Yes | | | | No | | | | | | | | | | |
| If Professional Visit Occurred Prior to Signature Dates, Emergency Documented on PVPN or Contact Log | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | | No | | | | NA | | | | | | | | | | | | | | | | | | | | | | |
| RN/LSW Updated Signatures within 10 Business Days when POC 2 Added | | | | | | | | | | | | | | | | | | | | | | | | Alterations Done Incorrectly | | | | | |
| Yes | | | No | | | | NA | | | | | | | | | | | | | | | | | Yes | | | No | NA | |
| Notes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **COMMUNICATION WITH MEDICAL PROVIDER** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provider Communicated with Medical Provider re: Beneficiary | | | | | | | | | | | | | | | | | | | | Followed Consent re: Beneficiary | | | | | | | | | |
| Yes | | | No | | | | | | | | | | | | | | | | | Yes | | | | No | | | | | |
| Provider Communicated with Medical Provider re: Caregiver | | | | | | | | | | | | | | | | | | | | Followed Consent re: Caregiver | | | | | | | | | |
| Yes | | | No | | | | | NA | | | | | | | | | | | | Yes | | | | No | | NA | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **BENEFICIARY STATUS NOTIFICATION AT ENROLLMENT (5640)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Present at Enrollment | | | | | | | | | Beneficiary Info Section Complete and Accurate\*\* | | | | | | | | | | | | | | | | | | | | |
| Yes | | | No | | | | | | Yes | | No | | | | | | | | | | | | | | | | | | |
| Checkbox Section Complete and Accurate\*\* | | | | | | | | | | | | | | | Staff Info Section Complete and Accurate\*\* | | | | | | | | | | | | | | |
| Yes | | | No | | | | | | | | | | | | Yes | | No | | | | | | | | | | | | |
| Sent within 14 Calendar Days of Risk Identifier Date | | | | | | | | | | | | | | | | | | | | Alterations Done Incorrectly | | | | | | | | | |
| Yes | | | No | | | | | | | | | | | | | | | | | Yes | | | | No | | NA | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **COMMUNICATION FORM (5638/5639)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Communication Form Present | | | | | | | | | | | | | | Beneficiary Info Section Complete and Accurate\*\* | | | | | | | | | | | | | | | |
| Yes | | No | | | | | | | | | | | | Yes | | No | | | | | | | | | | | | | |
| RI Score Summary Matches POC 2 from RI | | | | | | | | | | | | | | Professional Signature Section Complete and Accurate\*\* | | | | | | | | | | | | | | | |
| Yes | | No | | | | | | | | | | | | Yes | | No | | | | | | | | | | | | | |
| Alterations Done Incorrectly | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | No | | | | | | NA | | | | | | | | | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **BENEFICIARY STATUS NOTIFICATION AT TRANSFER (5640)**  NA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Present at Transfer | | | | | | | | | Beneficiary Info Section Complete and Accurate\*\* | | | | | | | | | | | | | | | | | | | | |
| Yes | | | No | | | NA | | | Yes | | No | | NA | | | | | | | | | | | | | | | | |
| Checkbox Section Complete and Accurate\*\* | | | | | | | | | | | | | | | Staff Info Section Complete and Accurate\*\* | | | | | | | | | | | | | | |
| Yes | | | No | | | NA | | | | | | | | | Yes | | | No | | | NA | | | | | | | | |
| Sent within 14 Calendar Days of Transfer | | | | | | | | | | | | | | | Alterations Done Incorrectly | | | | | | | | | | | | | | |
| Yes | | | No | | | NA | | | | | | | | | Yes | | | No | | | NA | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **BENEFICIARY STATUS NOTIFICATION AT DISCHARGE (5640)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Present at Discharge | | | | | | | | | Beneficiary Info Section Complete and Accurate\*\* | | | | | | | | | | | | | | | | | | | | |
| Yes | | No | | | NA | | | | Yes | | No | | NA | | | | | | | | | | | | | | | | |
| Checkbox Section Complete and Accurate\*\* | | | | | | | | | | | | | | | “Discharge Summary Attached” Checked | | | | | | | | | | | | | | |
| Yes | | No | | | NA | | | | | | | | | | Yes | | | No | | | NA | | | | | | | | |
| Staff Info Section Complete and Accurate\*\* | | | | | | | | | | | | | | | Sent within 14 Calendar Days of Discharge Summary Date | | | | | | | | | | | | | | |
| Yes | | No | | | NA | | | | | | | | | | Yes | | | No | | | NA | | | | | | | | |
| Alterations Done Incorrectly | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | No | | | NA | | | | | | | | | | | | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **BENEFICIARY TRANSFER (5646, 5699/5646, 5708)**  NA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consent to Transfer MIHP Records Present | | | | | | | | | | | | | | | Both Providers Listed | | | | | | | | | | | | | | |
| Yes | No | | | NA | | | | | | | | | | | Yes | | | No | | | NA | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Health Info Checkbox (one or more boxes checked) | | | | | | | | Consent Checkbox (one checked) | | | | | | | |
| Yes | No | NA | | | | | | Yes | | No | | NA | | | |
| Beneficiary Info Section Complete and Accurate\*\* | | | | | | Professional Info Section Complete and Accurate\*\* | | | | | | | | | |
| Yes | No | NA | | | | Yes | | No | NA | | | | | | |
| Alterations Done Incorrectly | | | | | | Transfer Checklist Present | | | | | | | | | |
| Yes | No | NA | | | | Yes | | No | NA | | | | | | |
| Alterations Done Incorrectly | | | | | | Documents Received Prior to First Professional Visit | | | | | | | | | |
| Yes | No | NA | | | | Yes | | No | NA | | | | | | |
| If First Professional Visit Done Prior to Documents Being Received, Emergency Documented on PVPN or Contact Log | | | | | | | | | | | | | | | |
| Yes | No | NA | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **DISCHARGE SUMMARY** | | | | | | | | | | | | | | | |
| Infant: 18 Month Birthday | | | | Maternal: 60th Day Postpartum | | | | | Date of Discharge Summary | | | | | | |
|  | | | NA |  | | | NA | |  | | | | | | NA |
| Infant: Completed within 30 Days of 18 Month Birthday | | | | | | Maternal: Completed 30 days after End of Month in which 60th Day Postpartum Falls | | | | | | | | | |
| Yes | No | NA | | | | Yes | | No | NA | | | | | | |
| Alterations Done Incorrectly | | | | | | Infant: Visits Continued Past 18 Months | | | | | | | | | |
| Yes | No | NA | | | | Yes | | No | NA | | | | | | |
| Infant: Authorized to Continue Past 18 Months | | | | | | | | | | | | | | | |
| Yes | No | NA | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **NOTIFICATION OF MULTIPLE CHARTS OPEN (5704)** | | | | | | | | | | | | | | | |
| Present | | | | All Beneficiaries Identified | | | | | Alterations Done Incorrectly | | | | | | |
| Yes | No | NA | | Yes | No | NA | | | Yes | | | | No | NA | |
| Infant: Part of Multiple Birth | | | | Infant: IRI Present for Sibling(s) | | | | | Infant: POC 2 Present for Sibling(s) | | | | | | |
| Yes | No | NA | | Yes | No | NA | | | Yes | | | | No | NA | |
| Infant: POC 3 Present for Sibling(s) | | | | | | Infant: Discharge Summary Present for Sibling(s) | | | | | | | | | |
| Yes | No | NA | | | | Yes | | No | NA | | | | | | |
| Notes | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **MCIR** | | | | | | | | | | | | | | | |
| Date MCIR Pulled | | | | | | Infant: Date Infant Turned 5 Months Old | | | | | | | | | |
|  | | | | | |  | | | | | NA | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Infant: Pulled for Visit at 5 Months Old or Subsequent Visit | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | No | | | | | NA | | | | | | | | | | | | | | | | | | | | | | | | | |
| If Infant MCIR not pulled in appropriate timeframe, reason documented on PVPN or Contact Log | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | No | | | | | NA | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maternal: Pulled While Enrolled | | | | | | | | | | | | | If Maternal MCIR not pulled, reason documented on Contact Log | | | | | | | | | | | | | | | | | | |
| Yes | No | | | | | NA | | | | | | | Yes | | | No | | | NA | | | | | | | | | | | | |
| Alterations Done Incorrectly | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | No | | | | | NA | | | | | | | | | | | | | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PROFESSIONAL VISIT PROGRESS NOTE REVIEW** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Beneficiary Domains Present in POC 2** | | | | | | | | | | | | | | | | | **Risk Level** | | | | | | | | | | | | **Visit Number First Addressed** | | |
| **Infant Domains** | | | | | | | | | | | | | | | | |  | | |  | | | | | |  | | |  | | |
| Family and Social Support | | | | | | | | | | | | | | | | |  | | | Moderate | | | | | |  | | |  | | |
| Infant Health Care | | | | | | | | | | | | | | | | | Low | | | Moderate | | | | | | High | | |  | | |
| Infant Safety | | | | | | | | | | | | | | | | |  | | |  | | | | | | High | | |  | | |
| Infant Feeding | | | | | | | | | | | | | | | | |  | | | Moderate | | | | | | High | | |  | | |
| General Infant Development | | | | | | | | | | | | | | | | |  | | | Moderate | | | | | |  | | |  | | |
| Substance Exposed Infant | | | | | | | | | | | | | | | | | Low | | | Moderate | | | | | | High | | |  | | |
| Infant Breastfeeding | | | | | | | | | | | | | | | | |  | | | Moderate | | | | | | High | | |  | | |
| **Maternal Domains** | | | | | | | | | | | | | | | | |  | | |  | | | | | |  | | |  | | |
| Pregnancy Health | | | | | | | | | | | | | | | | |  | | | Moderate | | | | | | High | | |  | | |
| Medical Considerations | | | | | | | | | | | | | | | | | Low | | | Moderate | | | | | |  | | |  | | |
| Family Planning | | | | | | | | | | | | | | | | | Low | | | Moderate | | | | | |  | | |  | | |
| Food/Nutrition | | | | | | | | | | | | | | | | | Low | | | Moderate | | | | | | High | | |  | | |
| Tobacco | | | | | | | | | | | | | | | | |  | | | Moderate | | | | | |  | | |  | | |
| Alcohol | | | | | | | | | | | | | | | | |  | | | Moderate | | | | | | High | | |  | | |
| Substance Misuse | | | | | | | | | | | | | | | | |  | | | Moderate | | | | | | High | | |  | | |
| Stress/Depression | | | | | | | | | | | | | | | | | Low | | | Moderate | | | | | | High | | |  | | |
| Social Support | | | | | | | | | | | | | | | | |  | | | Moderate | | | | | |  | | |  | | |
| Abuse/Violence | | | | | | | | | | | | | | | | |  | | | Moderate | | | | | | High | | |  | | |
| Housing | | | | | | | | | | | | | | | | |  | | | Moderate | | | | | | High | | |  | | |
| Transportation | | | | | | | | | | | | | | | | |  | | | Moderate | | | | | |  | | |  | | |
| Breastfeeding | | | | | | | | | | | | | | | | | Low | | | Moderate | | | | | | High | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Safety Plan Required and Intervention Number** | | | | | | | | | | | | | | | | | | | | | | | | | | | **Safety Plan Intervention Documented** | | | | |
| Stress/Depression | | | | | | | | | | | #13 | | | | | | Yes | | | | | | No | | | | Yes | | | | No |
| Abuse/Violence | | | | | | | | | | | #12 | | | | | | Yes | | | | | | No | | | | Yes | | | | No |
| Substance Exposed Infant | | | | | | | | | | | #9 | | | | | | Yes | | | | | | No | | | | Yes | | | | No |
| Infant Safety | | | | | | | | | | | #6 | | | | | | Yes | | | | | | No | | | | Yes | | | | No |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referral Topic: List Below (Include those Initiated at Assessment Visit)** | | | | | | | | | | | | **Visit Number Initiated (Assessment Visit=0)** | | | | | | **Follow Up Visit Number** | | | **If Follow Up Did Not Occur within 3 Visits, Reason Documented on PVPN or Contact Log** | | | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | |  | | | Yes | | | | No | | | | | NA | |
|  | | | | | | | | | | | |  | | | | | |  | | | Yes | | | | No | | | | | NA | |
|  | | | | | | | | | | | |  | | | | | |  | | | Yes | | | | No | | | | | NA | |
|  | | | | | | | | | | | |  | | | | | |  | | | Yes | | | | No | | | | | NA | |
|  | | | | | | | | | | | |  | | | | | |  | | | Yes | | | | No | | | | | NA | |
|  | | | | | | | | | | | |  | | | | | |  | | | Yes | | | | No | | | | | NA | |
|  | | | | | | | | | | | |  | | | | | |  | | | Yes | | | | No | | | | | NA | |
|  | | | | | | | | | | | |  | | | | | |  | | | Yes | | | | No | | | | | NA | |
|  | | | | | | | | | | | |  | | | | | |  | | | Yes | | | | No | | | | | NA | |
|  | | | | | | | | | | | |  | | | | | |  | | | Yes | | | | No | | | | | NA | |
|  | | | | | | | | | | | |  | | | | | |  | | | Yes | | | | No | | | | | NA | |
| **PROFESSIONAL VISIT PROGRESS NOTE #1** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date | | | | | | | | | | | | | | | | | | | Beneficiary Info Section Complete and Accurate\*\* | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | Yes | | | No | | | | | | | | | |
| Visit Last 30+ Minutes | | | | | | | | | | | | | | | | | | | If a Community Visit, Reason Documented | | | | | | | | | | | | |
| Yes | | | No | | | | | | | | | | | | | | | | Yes | | | No | | NA | | | | | | | |
| Content Addressed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Plan of Care Domain | | | | | | | | | | | | | Beneficiary Concern | | | | | | | | | | | Professional Judgement | | | | | | | |
| Beneficiary Reaction to Intervention Provided Complete | | | | | | | | | | | | | | | | | | | | | | | | Checklist Section Complete | | | | | | | |
| Yes | | | No | | | | | NA | | | | | | | | | | | | | | | | Yes | | | | No | | | |
| Action Plan Checked | | | | | | | | | | | | | Beneficiary Feedback and Desired Plan for Next Visit Complete | | | | | | | | | | | | | | | | | | |
| Yes | | | No | | | | | | | | | | Yes | | | No | | | | | | | | | | | | | | | |
| Specific Plan for Next Visit - Staff Complete | | | | | | | | | | | | | | | | | | | Professional Info Section Complete and Accurate\*\* | | | | | | | | | | | | |
| Yes | | | No | | | | | | | | | | | | | | | | Yes | | | No | | | | | | | | | |
| Profession Completing Visit | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RN | | | | LSW | | | | | | RD | | | | | Other | | | | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PROFESSIONAL VISIT PROGRESS NOTE #2** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date | | | | | | | | | | | | | | | | | | | Beneficiary Info Section Complete and Accurate\*\* | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | Yes | | | No | | | | | | | | | |
| Visit Last 30+ Minutes | | | | | | | | | | | | | | | | | | | If a Community Visit, Reason Documented | | | | | | | | | | | | |
| Yes | | No | | | | | | | | | | | | | | | | | Yes | | | No | | NA | | | | | | | |
| Content Addressed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Plan of Care Domain | | | | | | | | | | | | | Beneficiary Concern | | | | | | | | | | | Professional Judgement | | | | | | | |
| Beneficiary Reaction to Intervention Provided Complete | | | | | | | | | | | | | | | | | | | | | | | | Checklist Section Complete | | | | | | | |
| Yes | | No | | | | | | NA | | | | | | | | | | | | | | | | Yes | | | | No | | | |
| Action Plan Checked | | | | | | | | | | | | | Beneficiary Feedback and Desired Plan for Next Visit Complete | | | | | | | | | | | | | | | | | | |
| Yes | | No | | | | | | | | | | | Yes | | | No | | | | | | | | | | | | | | | |
| Specific Plan for Next Visit - Staff Complete | | | | | | | | | | | | | | | | | | | Professional Info Section Complete and Accurate\*\* | | | | | | | | | | | | |
| Yes | | No | | | | | | | | | | | | | | | | | Yes | | | No | | | | | | | | | |
| Profession Completing Visit | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RN | | | | LSW | | | | | | RD | | | | | Other | | | | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PROFESSIONAL VISIT PROGRESS NOTE #3** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date | | | | | | | | | | | | | | | | | | | Beneficiary Info Section Complete and Accurate\*\* | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | Yes | | | No | | | | | | | | | |
| Visit Last 30+ Minutes | | | | | | | | | | | | | | | | | | | If a Community Visit, Reason Documented | | | | | | | | | | | | |
| Yes | | No | | | | | | | | | | | | | | | | | Yes | | | No | | NA | | | | | | | |
| Content Addressed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Plan of Care Domain | | | | | | | | | | | | | Beneficiary Concern | | | | | | | | | | | Professional Judgement | | | | | | | |
| Beneficiary Reaction to Intervention Provided Complete | | | | | | | | | | | | | | | | | | | | | | | | Checklist Section Complete | | | | | | | |
| Yes | | No | | | | | NA | | | | | | | | | | | | | | | | | Yes | | | | No | | | |
| Action Plan Checked | | | | | | | | | | | | | Beneficiary Feedback and Desired Plan for Next Visit Complete | | | | | | | | | | | | | | | | | | |
| Yes | | No | | | | | | | | | | | Yes | | | No | | | | | | | | | | | | | | | |
| Specific Plan for Next Visit - Staff Complete | | | | | | | | | | | | | | | | | | | Professional Info Section Complete and Accurate\*\* | | | | | | | | | | | | |
| Yes | | No | | | | | | | | | | | | | | | | | Yes | | | No | | | | | | | | | |
| Profession Completing Visit | | | | | | | | | | | | | | | | | | | All High Risk Domains Addressed | | | | | | | | | | | | |
| RN | | | | | LSW | | | | RD | | | | | Other | | | | | Yes | | | No  NA | | | | | | | | | |
| If All High Risk Domains Have Not Been Addressed, Reason Documented on PVPN or Contact Log | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | No | | | | | NA | | | | | | | | | | | | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PROFESSIONAL VISIT PROGRESS NOTE #4** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date | | | | | | | | | | | | | | | | | | | Beneficiary Info Section Complete and Accurate\*\* | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | Yes | | | No | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Visit Last 30+ Minutes | | | | | | | | | | If a Community Visit, Reason Documented | | | |
| Yes | No | | | | | | | | | Yes | No | NA | |
| Content Addressed | | | | | | | | | | | | | |
| Plan of Care Domain | | | | | | | Beneficiary Concern | | | | | Professional Judgement | |
| Beneficiary Reaction to Intervention Provided Complete | | | | | | | | | | | | Checklist Section Complete | |
| Yes | No | | | NA | | | | | | | | Yes | No |
| Action Plan Checked | | | | | | | Beneficiary Feedback and Desired Plan for Next Visit Complete | | | | | | |
| Yes | No | | | | | | Yes | | No | | | | |
| Specific Plan for Next Visit - Staff Complete | | | | | | | | | | Professional Info Section Complete and Accurate\*\* | | | |
| Yes | No | | | | | | | | | Yes | No | | |
| Profession Completing Visit | | | | | | | | | | | | | |
| RN | | | LSW | | | RD | | Other | | | | | |
| Notes | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **PROFESSIONAL VISIT PROGRESS NOTE #5** | | | | | | | | | | | | | |
| Date | | | | | | | | | | Beneficiary Info Section Complete and Accurate\*\* | | | |
|  | | | | | | | | | | Yes | No | | |
| Visit Last 30+ Minutes | | | | | | | | | | If a Community Visit, Reason Documented | | | |
| Yes | No | | | | | | | | | Yes | No | NA | |
| Content Addressed | | | | | | | | | | | | | |
| Plan of Care Domain | | | | | | | Beneficiary Concern | | | | | Professional Judgement | |
| Beneficiary Reaction to Intervention Provided Complete | | | | | | | | | | | | Checklist Section Complete | |
| Yes | No | | | | NA | | | | | | | Yes | No |
| Action Plan Checked | | | | | | | Beneficiary Feedback and Desired Plan for Next Visit Complete | | | | | | |
| Yes | No | | | | | | Yes | | No | | | | |
| Specific Plan for Next Visit - Staff Complete | | | | | | | | | | Professional Info Section Complete and Accurate\*\* | | | |
| Yes | No | | | | | | | | | Yes | No | | |
| Profession Completing Visit | | | | | | | | | | | | | |
| RN | | | LSW | | | RD | | Other | | | | | |
| Notes | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **REQUIRED DISCIPLINES** | | | | | | | | | | | | | |
| RN & LSW Both Conducted a Visit | | | | | | | | | | If Not, Reason Documented on Contact Log | | | |
| Yes | | No | | | | | | | | Yes | No | NA | |
| Notes | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |

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| **PLAN OF CARE, 2** | | | | | | | | | | | | | | | | | | | | | | |
| All Domains Addressed Prior to Discharge | | | | | | | | | | | If Not, Reason Documented on Contact Log | | | | | | | | | | | |
| Yes | No | | | | | | | | | | Yes | | | No | | | | NA | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **MATERNAL HOME VISITS** | | | | | | | | | | | | | | | | | | | | | | |
| Home Visit Occurred During Pregnancy | | | | | | | | | | | If Not, Reason Documented on Contact Log | | | | | | | | | | | |
| Yes | No | | | NA | | | | | | | Yes | | | No | | | | NA | | | | |
| Home Visit Occurred Postpartum | | | | | | | | | | | If Not, Reason Documented on Contact Log | | | | | | | | | | | |
| Yes | No | | | NA | | | | | | | Yes | | | No | | | | NA | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **SAFETY PLAN** | | | | | | | | | | | | | | | | | | | | | | |
| If Safety Plan Required, Intervention Documented | | | | | | | | | | | If Required and not Documented, Reason Documented on Contact Log | | | | | | | | | | | |
| Yes | No | | | NA | | | | | | | Yes | | | No | | | | NA | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **ACTION PLAN** | | | | | | | | | | | | | | | | | | | | | | |
| Action Plan is Documented (checkbox) | | | | | | | | | If not Documented, Reason Documented on Contact Log | | | | | | | | | | | | | |
| Yes | No | | | | | | | | Yes | | | No | NA | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **STRESS/DEPRESSION REFERRAL** | | | | | | | | | | | | | | | | | | | | | | |
| If Stress/Depression Domain Present in POC 2, Referral Documented | | | | | | | | | | | If Referral Not Documented, Reason Documented on Contact Log | | | | | | | | | | | |
| Yes | No  NA | | | | | | | | | | Yes | | | No | | | | NA | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **REGISTERED DIETICIAN REFERRAL** | | | | | | | | | | | | | | | | | | | | | | |
| Food/Nutrition Domain Present and High Risk | | | | | | | | | | | If Yes, Internal RD Conducted a Visit or RD Referral Documented | | | | | | | | | | | |
| Yes | No | | | | | | | | | | Yes | | | No | | | | NA | | | | |
| If RD Did not Conduct a Visit and No RD Referral Occurred, Reason Documented on Contact Log | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | No | | | NA | | | | | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **MATERNAL-ONLY PROVIDER: INFANT MIHP REFERRAL** | | | | | | | | | | | | | | | | | | | | | | |
| Referral to Infant MIHP Provider Documented | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | No | | | NA | | | | | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **PHYSICIAN ORDER: RD SERVICES** | | | | | | | | | | | | | | | | | | | | | | |
| RD Conducted a Professional Visit | | | | | | | | | | | Order for RD Services Present in Chart | | | | | | | | | | | |
| Yes | | No | | | | | | | | | Yes | | | No | | | | NA | | | | |
| MIHP Provider Name Present on Order | | | | | | | | | | | Medical Provider Contact Info Present on Order | | | | | | | | | | | |
| Yes | | No | | | NA | | | | | | Yes | | | No | | | | NA | | | | |
| Medical Provider Signature, Credentials, Date Present on Order | | | | | | | | | | | | | | | | | | Rationale Present | | | | |
| Yes | | No | | | NA | | | | | | | | | | | | | Yes | | No | | NA |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **PHYSICIAN ORDER: MORE THAN 9 VISITS**  NA | | | | | | | | | | | | | | | | | | | | | | |
| More than 9 Visits Conducted | | | | | | | | | | | Order for Additional Visit Present in Chart | | | | | | | | | | | |
| Yes | No | | | | | | | | | | Yes | | | No | | | | NA | | | | |
| MIHP Provider Name Present on Order | | | | | | | | | | | Medical Provider Contact Info Present on Order | | | | | | | | | | | |
| Yes | No | | | NA | | | | | | | Yes | | | No | | | | NA | | | | |
| Medical Provider Signature, Credentials, Date Present on Order | | | | | | | | | | | | | | | | | | Rationale Present | | | | |
| Yes | No | | | NA | | | | | | | | | | | | | | Yes | | No | | NA |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **PHYSICIAN ORDER: MORE THAN 18 VISITS**  NA | | | | | | | | | | | | | | | | | | | | | | |
| More than 18 Visits Conducted | | | | | | | | | | | Order for Additional Visit Present in Chart | | | | | | | | | | | |
| Yes | No | | | | | | | | | | Yes | | | No | | | | NA | | | | |
| MIHP Provider Name Present on Order | | | | | | | | | | | Medical Provider Contact Info Present on Order | | | | | | | | | | | |
| Yes | No | | | NA | | | | | | | Yes | | | No | | | | NA | | | | |
| Medical Provider Signature, Credentials, Date Present on Order | | | | | | | | | | | | | | | | | | Rationale Present | | | | |
| Yes | No | | | NA | | | | | | | | | | | | | | Yes | | No | | NA |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **DEVELOPMENTAL SCREENING REVIEW**  NA | | | | | | | | | | | | | | | | | | | | | | |
| Birth Date | | | | | | | | | | | Gestational Age | | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | |
| **BRIGHT FUTURES** | | | | | | | | | | | | | | | | | | | | | | |
| Date Conducted | | | | | | | | | | | “Not Yet” Present | | | | | | | | | | | |
|  | | | | | | | | | | | Yes | | | No | | | | | | | | |
| Type of Screening Required for Follow-up (Bright Futures required for infants less than 1 month) | | | | | | | | | | | | | | | | | | | | | | |
| Bright Futures | | | | | | | ASQ-3 | | | | | | | | | | | | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| Bright Futures Follow Up Conducted | | | | | | | | | | | Date Conducted | | | | | | | | | | | |
| Yes | | No | | NA | | | | | | |  | | | | | | | | | | | |
| Correct Screener Used | | | | | | | | | | | "Not Yet" Present | | | | | | | | | | | |
| Yes | | No | | NA | | | | | | | Yes | | | No | | | | NA | | | | |
| Notes | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **ASQ-3** | | | | | | | | | | | | | | | | | | | | | | |
| Date of First Visit | | | | | | | | | | | Date of First ASQ-3 | | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | |
| Reason Not Completed at First Visit Documented | | | | | | | | | | | Correct Screener Used | | | | | | | | | | | |
| Yes | | | No | | | NA | | | | | Yes | | | No | | | | | | | | |
| Information Summary Complete and Accurate\*\* | | | | | | | | | | | Outcome | | | | | | | | | | | |
| Yes | | | No | | | | | | | | White | | | | | Grey | | | Black | | | |
| Referral Present | | | | | | | | Outcome of Referral | | | | | | | | | | | | | | |
| Yes | | | No | | | NA | | Enrolled | | Declined | | | | | Didn’t Qualify | | | | | | In Progress | |
| Learning Materials Provided | | | | | | | | | | | Rescreen Requirement | | | | | | | | | | | |
| Yes | | | No | | | NA | | | | | 4 months | | | | | | 2 months | | | | NA | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Notes | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Date of Second ASQ-3 | | | | | Reason Not Completed | | | | | | | Correct Screener Used | | | | |
|  | | | | | Yes | No | | NA | | | | Yes | | No | | NA |
| Information Summary Complete and Accurate\*\* | | | | | | | | Outcome | | | | | | | | |
| Yes | | No | | | | | | White | | Grey | | | Black | | | |
| Referral Present | | | | | Outcome of Referral | | | | | | | | | | | |
| Yes | | No | NA | | Enrolled | | Declined | | Didn’t Qualify | | | | | | In Progress | |
| Learning Materials Provided | | | | | | | | Rescreen Requirement | | | | | | | | |
| Yes | | No | NA | | | | | 4 months | | | 2 months | | | | NA | |
| Notes | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Date of Third ASQ-3 | | | | | Reason Not Completed | | | | | | | Correct Screener Used | | | | |
|  | | | | | Yes | No | | NA | | | | Yes | | No | | NA |
| Information Summary Complete and Accurate\*\* | | | | | | | | Outcome | | | | | | | | |
| Yes | No | | | | | | | White | | Grey | | | Black | | | |
| Referral Present | | | | | Outcome of Referral | | | | | | | | | | | |
| Yes | No | | NA | | Enrolled | | Declined | | Didn’t Qualify | | | | | | In Progress | |
| Learning Materials Provided | | | | | | | | Rescreen Requirement | | | | | | | | |
| Yes | No | | NA | | | | | 4 months | | | 2 months | | | | NA | |
| Notes | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Date of Fourth ASQ-3 | | | | | Reason Not Completed | | | | | | | Correct Screener Used | | | | |
|  | | | | | Yes | No | | NA | | | | Yes | | No | | NA |
| Information Summary Complete and Accurate\*\* | | | | | | | | Outcome | | | | | | | | |
| Yes | No | | | | | | | White | | Grey | | | Black | | | |
| Referral Present | | | | | Outcome of Referral | | | | | | | | | | | |
| Yes | No | | NA | | Enrolled | | Declined | | Didn’t Qualify | | | | | | In Progress | |
| Learning Materials Provided | | | | | | | | Rescreen Requirement | | | | | | | | |
| Yes | | No | | NA | | | | 4 months | | | 2 months | | | | NA | |
| Notes | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Date of Fifth ASQ-3 | | | | | Reason Not Completed | | | | | | | Correct Screener Used | | | | |
|  | | | | | Yes | No | | NA | | | | Yes | | No | | NA |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Information Summary Complete and Accurate\*\* | | | | | | Outcome | | | | | | |
| Yes | No | | | | | White | | Grey | | Black | | |
| Referral Present | | | | Outcome of Referral | | | | | | | | |
| Yes | No | | NA | Enrolled | Declined | | Didn’t Qualify | | | | In Progress | |
| Learning Materials Provided | | | | | | Rescreen Requirement | | | | | | |
| Yes | No | | NA | | | 4 months | | | 2 months | | NA | |
| Notes | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **ASQ: SE-2** | | | | | | | | | | | | |
| 2 Month Tool Completed | | | | | | Date of Completion | | | | | | |
| Yes | No | NA | | | |  | | | | | | |
| Reason Not Completed, Documented on PVPN or Contact Log | | | | | | | | | | | | |
| Yes | No | NA | | | | | | | | | | |
| In Correct Timeframe (1 month, 0 days – 2 months, 30 days) | | | | | | | | | | | | |
| Yes | No | NA | | | | | | | | | | |
| Information Summary Complete and Accurate\*\* | | | | | | Outcome | | | | | | |
| Yes | No | NA | | | | White | | Grey | | Black | | NA |
| Referral Present | | | | Outcome of Referral | | | | | | | | |
| Yes | No | NA | | Enrolled | Declined | | Didn’t Qualify | | | | In Progress | |
| Learning Materials Provided | | | | | | | | | | | | |
| Yes | No | NA | | | | | | | | | | |
| Notes | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| 6 Month Tool Completed | | | | | | Date of Completion | | | | | | |
| Yes | No | NA | | | |  | | | | | | |
| Reason Not Completed, Documented on PVPN or Contact Log | | | | | | | | | | | | |
| Yes | No | NA | | | | | | | | | | |
| In Correct Timeframe (3 months, 0 days – 8 months, 30 days) | | | | | | | | | | | | |
| Yes | No | NA | | | | | | | | | | |
| Information Summary Complete and Accurate\*\* | | | | | | Outcome | | | | | | |
| Yes | No | NA | | | | White | | Grey | | Black | | NA |
| Referral Present | | | | Outcome of Referral | | | | | | | | |
| Yes | No | NA | | Enrolled | Declined | | Didn’t Qualify | | | | In Progress | |
| Learning Materials Provided | | | | | | | | | | | | |
| Yes | No | NA | | | | | | | | | | |
| Notes | | | | | | | | | | | | |
|  | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 12 Month Tool Completed | | | | | | Date of Completion | | | | | |
| Yes | | No | NA | | |  | | | | | |
| Reason Not Completed, Documented on PVPN or Contact Log | | | | | | | | | | | |
| Yes | | No | NA | | | | | | | | |
| In Correct Timeframe (9 months, 0 days – 14 months, 30 days) | | | | | | | | | | | |
| Yes | | No | NA | | | | | | | | |
| Information Summary Complete and Accurate\*\* | | | | | | Outcome | | | | | |
| Yes | | No | NA | | | White | | Grey | Black | | NA |
| Referral Present | | | | Outcome of Referral | | | | | | | |
| Yes | | No | NA | Enrolled | Declined | | Didn’t Qualify | | | In Progress | |
| Learning Materials Provided | | | | | | | | | | | |
| Yes | | No | NA | | | | | | | | |
| Notes | | | | | | | | | | | |
|  | | | | | | | | | | | |
| 18 Month Tool Completed | | | | | | Date of Completion | | | | | |
| Yes | | No | NA | | |  | | | | | |
| Reason Not Completed, Documented on PVPN or Contact Log | | | | | | | | | | | |
| Yes | | No | NA | | | | | | | | |
| In Correct Timeframe (15 months, 0 days – 20 months, 30 days) | | | | | | | | | | | |
| Yes | No | | NA | | | | | | | | |
| Information Summary Complete and Accurate\*\* | | | | | | Outcome | | | | | |
| Yes | No | | NA | | | White | | Grey | Black | | NA |
| Referral Present | | | | Outcome of Referral | | | | | | | |
| Yes | No | | NA | Enrolled | Declined | | Didn’t Qualify | | | In Progress | |
| Learning Materials Provided | | | | | | | | | | | |
| Yes | No | | NA | | | | | | | | |
| Notes | | | | | | | | | | | |
|  | | | | | | | | | | | |
| \*See Operations Guide for specifics | | | | | | | | | | | |
| \*\*Complete and Accurate: all data elements are present and information is accurate | | | | | | | | | | | |
| Alterations: NA indicates no alterations were made. | | | | | | | | | | | |