

Healthy Start Encounter Form

A. Client Demographic Information

1. Client ID				2. Medicaid ID			
3. Last Name			Suffix	First Name			Middle Initial
4. Mailing Address (no. and street)					5. Zip Code		6. County
7a. Date of Birth		7b. DOB	8	9.	10.	11.	12.
mo day year		Verif.	Sex	Race	Ethnicity	Family ID	Relationship

13. Servicing Unit			14. Service Date			15. Special Group	16. Program Component (Check one only):						
a. Dist	b. Area	c. Unit	17. Svc Loc	mo	day	year	[]	22	26	27	30	31	32

B. Service Codes

INITIAL CONTACT	Svc. Code	# Svcs.	Position Number
Attempt to Contact	3103	_____	_____
Needs Tracking Only	3101	1	_____
Participant Needs Assessment	3102	1	_____
Declines Services	3110	1	_____
No Further Services Needed	3111	1	_____
Receiving or Will Receive	3112	1	_____
Care Coord. from CMS/Early Steps	3113	1	_____
Receiving or Will Receive	3113	1	_____
Care Coord. from Another Provider, not CMS/Early Steps	3114	1	_____
Unable to Locate	3114	1	_____
Unable to Complete Initial Contact	3119	1	_____
Initial Contact Service Units	3115	_____	_____

INITIAL ASSESSMENT	Svc. Code	# Svcs.	Position Number
Attempt to Contact	3203	_____	_____
Needs Tracking Only	3201	1	_____
Plan Ongoing Care Coordination	3202	1	_____
Declines Services	3210	1	_____
No Further Services Needed	3211	1	_____
Receiving or Will Receive	3212	1	_____
Care Coordination from CMS/EIP	3213	1	_____
Receiving or Will Receive	3213	1	_____
Care Coordination from Another Provider, not CMS/EIP	3214	1	_____
Unable to Locate	3214	1	_____
Unable to Complete Initial Assessment	3219	1	_____
Initial Assessment Service Units	3215	_____	_____

ONGOING CARE COORDINATION	Svc. Code	# Svcs.	Position Number
Attempt to Contact	3303	_____	_____
Care Coordination Face to Face*	3320	_____	_____
Care Coordination Tracking or not Face-to-Face*	3321	_____	_____
Initial Family Support Plan Meeting	3322	_____	_____
Update Family Support Plan	3323	_____	_____
Declines Services	3310	1	_____
No Further Services Needed	3311	1	_____
Receiving or Will Receiving	3312	_____	_____
Care Coordination From CMS/Early Steps	3313	1	_____
Receiving or Will Receive	3313	1	_____
Care Coordination from another Provider, not CMS/Early Steps	3314	1	_____
Unable to Locate	3314	1	_____
Ineligible for Services	3315	_____	_____
Transition to Interconceptional Care	3324	1	_____

ONGOING CARE COORDINATION DETAILS for 3320 and 3321*

Method of Contact Face-to-Face Home Visit

Plan of Care Evaluated Yes No

Plan of Care Changed Yes No

Education Provided (circle all that apply):

Baby Spacing/Family Planning Nutrition

Breastfeeding Parenting

Childbirth Pre-term Labor Danger Signs

Immunizations Shaken Baby Prevention

SIDS Risk Reduction Other

OTHER HEALTHY START SERVICES	Svc. Code	# Svcs.	Position Number
Nutrition Assessment/Counseling	4501	_____	_____
Psychosocial Counseling	8002	_____	_____
Parenting Support and Education	8004	_____	_____
Childbirth Education and Support	8006	_____	_____
Breastfeeding Education and Support	8008	_____	_____
Tobacco Education and Smoking Cessation Counseling	8026	_____	_____
Interconceptional Education and Counseling	8013	_____	_____

REFERRAL CODES	
<input type="checkbox"/> <u>Tobacco Use (Circle one below):</u>	
<input type="checkbox"/> Referral Made	<input type="checkbox"/> In Error
<input type="checkbox"/> Receiving Services	<input type="checkbox"/> Stopped Services
<input type="checkbox"/> Services Completed	<input type="checkbox"/> No Resources Available
<input type="checkbox"/> Unknown	<input type="checkbox"/> Client Did Not Follow-up
<input type="checkbox"/> Patient Declined	
<input type="checkbox"/> <u>Alcohol Use (Circle one below):</u>	
<input type="checkbox"/> Referral Made	<input type="checkbox"/> In Error
<input type="checkbox"/> Receiving Services	<input type="checkbox"/> Stopped Services
<input type="checkbox"/> Services Completed	<input type="checkbox"/> No Resources Available
<input type="checkbox"/> Unknown	<input type="checkbox"/> Client Did Not Follow-up
<input type="checkbox"/> Patient Declined	
<input type="checkbox"/> <u>Substance Use: (Circle on below):</u>	
<input type="checkbox"/> Referral Made	<input type="checkbox"/> In Error
<input type="checkbox"/> Receiving Services	<input type="checkbox"/> Stopped Services
<input type="checkbox"/> Services Completed	<input type="checkbox"/> No Resources Available
<input type="checkbox"/> Unknown	<input type="checkbox"/> Client Did Not Follow-up
<input type="checkbox"/> Patient Declined	