HEALTHY START INITIAL CONTACT

CONTACT INFORMATION

HEALTHY START CARE COORDINATOR NAME: ______________________________ PHONE: (___)____-_____

ADDRESS:____

HEALTH CARE PROVIDER NAME: ____ PHONE:(___)____-_____

ADDRESS: ____

HEALTHY START RISK SCREENING INFORMATION

Healthy Start Risk Score ____ Referred to Healthy Start Not Referred to Healthy Start

Date of Risk Screen ___/___/_____ Date received by CHD ___/___/____ Date received by Care Coordinator ___/___/___

INITIAL CONTACT INFORMATION

1st Attempt: Date: ___/___/_____ Method: phone letter face-to-face

2nd Attempt: Date: ___/___/_____ Method: phone letter face-to-face

3rd Attempt: Date: ___/___/_____ Method: phone letter face-to-face

Completion Date: ___/___/_____ Method: phone face-to-face

1. Healthy Start risk factors identified are checked below:

√	**Risk Factor(s)**	Risks, intervention and/or referrals as discussed with participant along with plan of care:
	Age <18	
	Race-Black	
	Not married	
	<12 or GED education	
	Body Mass Index (BMI)	
	Tobacco use	
	Poor pregnancy timing	
	Chronic Illness	
	2nd trimester care	
	Infant's wt. <2000 grams	
	Abnormal condition	
	Congenital anomaly	
	Poor pregnancy outcome	
	Alcohol/other drug use	
	First pregnancy	
	Felt down, depressed, hopeless	
	Pregnancy Interval < 18 months	

2. Additional family needs/strengths to be addressed by the participant and the Healthy Start care coordinator:

   ____

3. Participant able to access comprehensive prenatal or infant health care: Yes No

4. Additional health education or referrals provided during initial contact marked below. **R=referral; E= education**

PTL Danger Signs		WIC/ Nutrition Counseling		Immunizations	
Shaken Baby Prevention		Childbirth Education		Parenting Support/Education	
SIDS Risk Reduction		Baby Spacing/Family Planning		Psychosocial Counseling	
Breastfeeding					

5. Name and phone number of Healthy Start contact person provided to participant: **Yes No**

6. **Plan of Care: Yes No Client Level: _____**

_______Will follow-up with participant to track receipt of referrals.

_______Participant scheduled for further Healthy Start assessment on (date)___/___/_____.

_______Plan ongoing Healthy Start care coordination with participant.

_______Participant declines further services from the Healthy Start program.

_______Participant needs no further services from Healthy Start at this time; please refer again if situation changes.

_______Participant receiving care coordination from CMS Early Steps. Closed to Healthy Start.

_______Participant receiving care coordination from (specify) __________________. Closed to Healthy Start.

_______No response from participant after documented attempt(s) to contact – participant closed to Healthy Start.

Healthy Start Signature/Title: ____ Date: ___/___/_____

7. Health Care Provider Notified: Yes No Date: ___/___/_____

Name: ______________________________

ID No: ______________________

Date of Birth: ___/___/_____

INSTRUCTIONS FOR DOCUMENTATION OF INITIAL CONTACT

This form is to be used by the provider to document all initial contact activities. A copy will be entered into the participant's record and a copy may be sent to the health care provider. This form will document all of the information for the initial contact which is required by the Healthy Start Care Coordination Rule (64F-3, F.A.C.). It is not an assessment tool. Any additional information may be provided on a progress note.

Complete the Healthy Start care coordinator and health care provider name, phone and address.

Note the participant's Healthy Start screening score or check whether the participant was referred for factors other than score or was self referred. Provide appropriate dates.

All the dates and methods of attempted contact should appear on this form, thereby eliminating the need for more than one form.

1. **Check all risk factors from the Healthy Start Screen which resulted in initial contact. List risk factors discussed at the initial contact other than those identified on the Healthy Start screen, including those identified through your professional judgment or participant conversation. Write in your intervention or referral in the table to the right of the risk factor.**
2. **List additional needs/strengths to be addressed, such as concerns, priorities, assets and resources that are identified by the participant. Concerns might include lack of education or a job; priorities might include child care or WIC; and resources might include family or friends' support, Medicaid, etc.**
3. **Indicate whether the participant is able to access comprehensive prenatal and infant health care (e.g. periodic screening, diagnosis and treatment; necessary laboratory tests; immunizations; WIC; family planning; health education and counseling; acute care; and referral for needed services).**
4. **Mark all the appropriate boxes for additional health education or referrals provided during the initial contact. R=referral; E= education. Use blanks for "write in" health education or referrals provided during the initial contact.**
5. **Check if the contact person's name and phone number were supplied to the participant.**
6. **Check the appropriate plan of care based on the participant's concerns, priorities, strengths and resources. Enter date of planned assessments. Document level.**
   - **Check "track receipt of referrals" if tracking is planned at this time.**
   - **Check "scheduled for further Healthy Start assessment" if initial assessment planned within 10 days.**
   - **Check "Plan ongoing Healthy Start care coordination with participant" if initial contact and assessment completed and participant will continue with care coordination services.**
   - **Check "declines further services" if participant verbally declined services even though coordinator feels services are warranted at this time.**
   - **Check "needs no further services" if participant and care coordinator jointly agree no further care coordination services are needed at this time.**
   - **Check "coordination from CMS Early Steps or other specified provider if appropriate.**
   - **Check "no response from participant after documented attempt(s) to contact" if participant closed as unable to provide initial contact or assessment or unable to locate after multiple attempts to contact.**
7. **Check the appropriate box. Complete the date when a follow-up on the Initial Contact was sent to the primary or prenatal health care provider. Enter the signature and phone number of the person providing the initial contact and the date.**