OneCare Kansas Health Action Plan (HAP)

SECTION I. DEMOGRAPHIC INFORMATION			
Member Information:			
Last Name:	**First Name:**	**MI:**	**Medicaid ID:**
Member in Institution: ☐ Yes ☐ No	**Date Entered Institution:**	**Date Discharged from Institution:**	

Physical Address:	**City:**	**State:**	**Zip:**	**County:**
Mailing Address:	**City:**	**State:**	**Zip:**	**County:**

Phone:	**Date of Birth:**	**Gender:** ☐ Female ☐ Male ☐ Other:

Race: ☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black or African American ☐ Pacific Islander ☐ White ☐ Other

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other	**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

SECTION II. ADDITIONAL CONTACT INFORMATION		
OneCare Kansas Partner:		
OCK Partner (Business Name):		
OCK Care Coordinator:	**Last Name:**	**First Name:**

Medical Power of Attorney:				
Last Name:			**First Name:**	
Address:	**City:**	**State:**	**Zip:**	**Phone:**

Parent/Foster Parent/Legal Guardian:				
Last Name:			**First Name:**	
Address:	**City:**	**State:**	**Zip:**	**Phone:**

Other Support Person:				
Relation to Member:	**Last Name:**			**First Name:**
Address:	**City:**	**State:**	**Zip:**	**Phone:**

Are there additional support persons on file for this member? ☐ Yes ☐ No

SECTION III. EXISTING HCBS WAIVER PLAN OF CARE (IF APPLICABLE)

Do you have an existing HCBS Waiver Plan of Care? ☐ Yes ☐ No

Wavier Type:

☐ AU-Autism	☐ FE-Frail Elderly	☐ IDD-Intellectually Developmentally Disabled	☐ PD-Physically Disabled
☐ BI- Brain Injury	☐ TA-Technology Assistance	☐ SED-Severely Emotionally Disturbed	☐ Unknown

SECTION IV. ADVANCED DIRECTIVES

Do you have a Living Will? ☐ Yes ☐ No	**Do you have a Durable Power of Attorney?** ☐ Yes ☐ No

SECTION V. PHYSICAL, BEHAVIORAL HEALTH

OCK Qualifying Diagnoses; Check all that apply:

☐ Asthma	☐ Bipolar Disorder	☐ Cardiovascular Disease	☐ COPD	☐ Diabetes
☐ Exposure to Secondhand Smoke	☐ Hypertension	☐ Kidney Disease	☐ Major Depressive Disorder	☐ Metabolic Syndrome
☐ Morbid Obesity	☐ Schizophrenia	☐ Substance Use Disorder	☐ Tobacco Use	☐ Other Mental Illness

Health Assessment:

Did the MCO perform a Health Risk Assessment? ☐ Yes ☐ No		**Date:**
Did you perform a OneCare Health Assessment? ☐ Yes ☐ No ☐ Not Applicable		**Date:**

The OneCare Health Assessment is a recommendation and not a program requirement, OCK partners may use their own assessment tool for the OneCare Health Assessment. A sample OneCare Health Assessment can be found under OCK HAP Portal Documents.

PHQ-9 Score:		**Date:**
Substance Use Disorder Screening: ☐ Negative ☐ Positive ☐ Not Applicable	**Date:**	**Tool Used:**
If Positive; to Whom Referred:		

Tobacco and Nicotine Use:	**Date Quit:**	**Readiness to Quit:**
☐ Never Used ☐ Former User ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Smokeless ☐ E-Cigarettes ☐ Vaping ☐ Other Tobacco Products		☐ Not interested in quitting ☐ Would like to quit sometime (not in next month) ☐ Would like to quit now or soon (within next month)

Tobacco Cessation Offered: ☐ Yes ☐ No	**If Yes; to Whom Referred:**

Assessing Provider Type: ☐ Substance Use Disorder Provider ☐ Mental Health Provider ☐ Primary Care Provider
Provider Business Name:

Address:	**City:**	**State:**	**Zip:**	**Phone:**

Provider Contact:	**Last Name:**	**First Name:**

Physical Health:

Height (inches): ☐ Patient Declined	**Method:** ☐ Measured ☐ Current History/Physical	**Date:**
Weight: ☐ Patient Declined	**Date:**	**BMI:**
BP: / ☐ Not Clinically Indicated ☐ Patient Declined ☐ Not Available		**Date:**
A1c: ☐ Not Clinically Indicated ☐ Patient Declined ☐ Not Available		**Date:**
LDL: **HDL:** ☐ Not Clinically Indicated ☐ Patient Declined ☐ Not Available		**Date:**
Medication Reconciliation Performed? ☐ Yes ☐ No ☐ N/A		**Date Performed:**

Assessing Provider Type:	☐ Substance Use Disorder Provider	☐ Mental Health Provider	☐ Primary Care Provider

Provider Business Name:

Address:	City:	State:	ZIP:	Phone:

Provider Contact:	Last Name:	First Name:

SECTION VI. GOALS AND STEPS TO ACHIEVE

Member Goal:

Goal Start Date:	Percent Complete:

Goal Domain: ☐ Mental Health ☐ Substance Use Disorder ☐ Social Determinants of Health ☐ Physical Health

Focus Area:

☐ Diet	☐ Physical activity	☐ Personal Hygiene	☐ Tobacco use	☐ Weight
☐ Stress	☐ Chronic Illness	☐ Personal safety	☐ Housing	☐ Food
☐ Transportation	☐ Utilities	☐ Childcare	☐ Employment	☐ Education
☐ Mental Illness	☐ Depression	☐ Anxiety	☐ Medication Management	☐ Maintaining abstinence

☐ Accessing and/or completing an appropriate treatment program ☐ Other:

Completion Date:	Outcome: ☐ Complete ☐ Discontinued ☐ No Longer Pertinent ☐ Revised

Notes:

<table>
<tr><th colspan="6">Short-Term Goals:</th></tr>
<tr><td colspan="5">Short-Term Goal:</td><td>Percent Complete:</td></tr>
<tr><td colspan="2">Conviction (Scale 1-10):</td><td colspan="2">Confidence (Scale 1-10):</td><td colspan="2">Readiness: (Scale 1-10):</td></tr>
<tr><td colspan="6">Steps to Achieve Goal:</td></tr>
<tr><td colspan="6">Current Progress:</td></tr>
</table>

Strengths:
Needs:
Measurable Outcomes:

SECTION VII. Signatures

Required Signatures

Signature:	**Date:**
Completed by OCK Member	
Signature:	**Date:**
Completed by Social Worker / Care Coordinator	
Signature:	**Date:**
Completed by Nurse Care Coordinator	

Optional Signatures

Signature:	**Date:**
Completed by: ☐ Family Member ☐ Other:	
Signature:	**Date:**
Completed by: ☐ Family Member ☐ Other:	
Signature:	**Date:**
Completed by: ☐ Family Member ☐ Other:	
Signature:	**Date:**
Completed by: ☐ Family Member ☐ Other:	