Care Coordination/Follow-up Form: Completion Instructions

CHDP Providers:

- Submit a copy of the form, an EHR patient summary, or an equivalent via eFax to the Local CHDP program for a child with Fee-for-Service Medi-Cal or temporary Gateway Coverage if the child has been referred to another provider for the following:
  - Medical diagnosis
  - Medical treatment
  - Dental home
  - Dental treatment or
  - Scheduled for a return visit
- Give a copy of the form or a printout of your EHR patient summary or an equivalent to the responsible person indicated on the form.

Explanation of Form Items:

Patient Information (Demographics section)

Patient Name. Enter the patient's last name, first name and middle initial, exactly as it appears on the Benefits Identification Card (BIC), including blank spaces. If the patient's name differs in any way from the name on the BIC or is incorrect, enter the name that the patient is Also Known As (AKA) in the *Comments* area.

Language. Enter the patient's primary language spoken at home. The language is critical to enable local CHDP program staff to assist families in removing barriers to diagnosis and/or treatment.

Date of Service. Enter the date the CHDP service was rendered. Use a leading zero (0) when entering dates with only one digit (for example, March 1, 2017 is entered as 03 01 17).

Birthdate. Enter the month, day and year of the patient's birth exactly as it appears on the Medi-Cal eligibility verification system. Use zeros (0) when entering dates of only one digit (for example, January 1, 2017 is entered as 01 01 17). If the birth date stated on the Medi-Cal eligibility verification system is incorrect, note the discrepancy in the *Comments area.*

Age. Enter the patient's age with one of the following indicators: "y" for years, "m" for months, "w" for weeks, or "d" for days (for example, 15y represents 15 years of age).

Sex. Enter an "F" if the patient is female. Enter an "M" if the patient is male. This must be entered exactly as it appears on the Medi-Cal eligibility verification system. If the sex stated on the Medi-Cal eligibility verification system is incorrect, note this in the *Comments* area.

Gender. Enter the gender the patient identifies with even if the gender is not female or male. If information is not available leave blank.

Patient's County of Residence. Enter either the name of the county where patient lives (not county where assessment is performed) or the two-digit city code if the individual lives in Berkeley, Long Beach or Pasadena.

Telephone # Enter residence or cellular telephone number, including area code where the responsible person can be reached during the day. This number is critical to enable local CHDP program staff to assist families in linking to care.

Alternate Phone # Enter business or message telephone number, including area code where the responsible person can be reached during the day. This number is critical to enable local CHDP program staff to assist families in linking to care.

Responsible Person. When the patient is younger than 18 years of age and not an emancipated minor, enter the name, street address (including apartment or space number), city, and ZIP code of the parent or legal guardian with whom the patient lives.

Patient Eligibility. Patient eligibility information on the form is completed as follows:

- COUNTY. Enter patient's two-digit county code (obtained when eligibility verification is performed).
- AID CODE. Enter patient's two-digit aid code (obtained when eligibility verification is performed).
- IDENTIFICATION NUMBER. Enter patient's identification number from the plastic Benefits Identification Card (BIC) or
  - *Immediate Need Eligibility Document* – Gateway
- Enter a check mark (✔) on either Yes or No to indicate if the patient is enrolled with a Medi-Cal Managed Care Plan

Next CHDP Exam Date. Enter the month, day and year that the next complete health assessment is due.

Ethnic Code. Enter the appropriate ethnic code (select one only). If the patient's ethnicity is not included in the code list, or if ethnicity is unknown, enter code 7 (Other).

A. Medical Assessment and Referral Section:

No Medical Problems Suspected. Enter check mark (✔) in this box if the screenings, assessments and procedures are completed and no problem is suspected. Go to Section B - Dental Assessment and Referral.

Significant Medical History or Special Conditions. Enter diagnosis of medical history or special conditions that are known to the family per history and currently or previously under care that will assist in linking the patient with an appropriate dental home, as well as assist the CHDP PHN for care coordination and/or follow-up.

If a problem is suspected for any exam, assessment or screening areas (Physical, Nutritional, Developmental, Vision, and Hearing) enter the following:

1. The name and telephone number of the provider or agency you referred the patient.
2. If a diagnosis and/or treatment are pending and a return visit is scheduled enter the *Problem Suspected* in the designated area and enter check mark (✔) on the *Returned Visit Scheduled* box – any additional information may be placed in the *Comments* area.

Physical Exam. *Problem Suspected* – Enter up to 3 *problems suspected* in the designated area if diagnosis or treatment not known to the family per history and currently or previously not under care. Enter additional problem(s) suspected in the *Comments* area.

Nutritional Assessment. *Problem Suspected* – Enter the *problem suspected* in the designated area if a diagnosis or treatment not known to the family per history and currently or previously not under care. Enter additional problem(s) suspected in the *Comments* area.

Developmental Screening. *Problem Suspected* – Enter a check (✔) in appropriate box(es) if a diagnosis or treatment not known to the family per history and currently or previously not under care. Check (✔) *Other* box if the condition is not listed and enter the suspected diagnosis in the *Comments* area.

Vision and Hearing Screening. *Problem Suspected* – Enter a check mark (✔) on the *problem suspected* box if a diagnosis or treatment not known to the family per history and currently or previously not under care and enter the diagnosis or treatment in the *Comments* area. Enter additional information in the *Comments* area.

- Enter a check marks (✔) on the *Not screened* and the *Returned Visit Scheduled* boxes if the patient was not screened.
- Enter a check mark (✔) on the *Other* box and state the diagnosis or information in the space provided if the screening results do not fit with *Problem Suspected* or *Not screened* boxes. Enter any additional in the *Comments* area.

Comments. Use this space for remarks that clarify the results of the health assessment and communicate issues to the local CHDP programs. Dental Assessment and Referral Section

Class I. Enter a check mark (✔) on the *Class I: No Visible Problems* box if the patient has no visible problems and by checking this box you are indicating the patient is being referred for the *mandated annual routine dental referral.*

Class II. Enter a check mark (✔) on the *Class II: Visible decay box* if the patient has visible decay, small carious lesions or gingivitis and by checking this box you are indicating the patient is being referred for a *non-urgent dental care* referral.

Class III. Enter a check mark (✔) on the *Class III: Urgent* box if the patient has pain, abscess, large carious lesions or extensive gingivitis and by checking this box you are indicating the patient is being referred for *immediate treatment due to an urgent dental condition.*

Class IV. Enter a check mark (✔) on the *Class IV: Emergent acute injury* box if the patient has an acute injury, oral infection or other pain and by checking this box you are indicating the patient is being referred for *immediate dental treatment to be seen within 24 hours.*

Fluoride Varnish Applied.

- Enter a check mark (✔) on the Yes box if the patient had fluoride varnish applied during visit on date of service listed above.
- Enter a check mark (✔) on appropriate No boxes fluoride varnish was not applied due to either parent refusal or teeth have not erupted.
- Enter a check mark (✔) on the Other reason box and state reason for not applying fluoride varnish in the space provided.

Dental home referral. Enter a check mark (✔) on the *Dental home referral* box if the patient has no dental home.

Note: A referral for a routine dental visit still needs to be made if the patient has no dental problems (Class I) and is 1 year of age or older. Be sure to check (✔) Class I box.

Referred To and Contact Number. Enter the name and telephone number of the dental provider or agency where the patient was referred or enter the patient's dental home provider information.

- If the patient does not have a dental home, be sure to enter a check mark (✔) on the Dental home referral box and enter the name and telephone number of the dental provider or agency you referred the patient.

B. Referring Provider Information

Service Location. Enter the following information on the appropriate line:

- Line 1: Business Name
- Line 2: Street address
- Line 3: City, State and nine-digit ZIP code
- Line 4: Telephone number, including area code

A provider stamp is acceptable.

Provider Office NPI Number. Enter the office's National Provider Identifier (NPI) number in the appropriate line.

Rendering Provider Name. Print legibly or type the provider's name that renders the services.

Provider Signature. Provider or a designated representative must sign.

Date. Enter the date of signature.

Child Health and Disability Prevention Program

Care Coordination / Follow-up Form

Submit to the County CHDP Program within 5 business days of the examination - Fax: 714- 834-7948; CHDP Program, P.O. Box 6099, Santa Ana, CA 92706

Do not complete this form if child is in the foster care system. Health Care providers are required to submit a HCPCFC Foster Care Medical (Specialty)/ Dental Contact Form for all types of appointments. For foster children - providers only complete page 2.

Patient Name (Last) (First) (Initial)	Language	Date of Service Month Day Year

Birthdate Month Day Year	Age	Sex	Gender	Patient's County of Residence	Telephone # (Home or Cell)	Alternate Phone # (Work or Other)
					( )	( )

Responsible Person (Name) (Street) (Apt/Space #) (City) (Zip)	Ethnic Code
	☐ 1. White 2. Hispanic/Latino 3. Black/African American 4. American Indian/Alaska Native 5. Asian 6. Native Hawaiian/Other Pacific Islander 7. Other

Patient Eligibility	County	Aid Code	Identification Number	Next CHDP Exam Date: Month Day Year

A. Medical Assessment and Referral Section

☐ No Medical Problems Suspected

Significant Medical History or Special Conditions: ☐ No ☐ Yes, Specify: _____

	Problem Suspected	Referred To & Contact # Or ☐ Return Visit Scheduled	Comments:
Physical Exam	Problem Suspected	Referred To & Contact # Or ☐ Return Visit Scheduled	
	Problem Suspected	Referred To & Contact # Or ☐ Return Visit Scheduled	
Nutritional Assessment	Problem Suspected	Referred To & Contact # Or ☐ Return Visit Scheduled	
Developmental Screening	☐ Speech Delay ☐ Social/Emotional ☐ Cognitive ☐ Fine Motor Delay ☐ Gross Motor Delay ☐ Other	Referred To & Contact # Or ☐ Return Visit Scheduled	
Vision Screening	☐ Problem Suspected ☐ Not screened – rescheduling ☐ Other: _____	Referred To & Contact # Or ☐ Return Visit Scheduled	
Hearing Screening	☐ Problem Suspected ☐ Not screened – rescheduling ☐ Other: _____	Referred To & Contact # Or ☐ Return Visit Scheduled	

B. Dental Assessment and Referral Section

☐ **Class I:** No Visible Problems

Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)

☐ **Class II:** Visible decay, small carious lesion or gingivitis

Needs non-urgent dental care

☐ **Class III: Urgent** – pain, abscess, large carious lesions or extensive gingivitis

Immediate treatment for urgent dental condition which can progress rapidly

☐ **Class IV: Emergent** – acute injury, oral infection or other pain

Needs immediate dental treatment within 24 hours

Fluoride Varnish Applied: ☐ Yes ☐ No, parent refused ☐ No, teeth have not erupted
☐ Other reason for not applying: _____

☐ **Dental home referral**

Referred To and Contact Number: _____

C. Referring Provider Information

Service Location: Office Name, Address, Telephone Number	Provider Office NPI Number
	Rendering Provider Name (Print Name)
	Provider Signature
	Date

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