

TCM Assessment

Babies First!, NFP and CaCoon
Targeted Case Management (TCM)
1 unit/encounter

TCM Care Eligibility (All must be checked to bill):

- The client has at least one eligibility criteria for Expanded Babies First!, Nurse-Family Partnership (NFP), or CaCoon.
 - The client is enrolled in a TCM program (please select one):
 - <5 years old (Babies First!)
 - <2years old (Nurse-Family Partnership)
 - <21 years old (CaCoon)
 - Pregnant or primary caregiver of an eligible child (Babies First!/NFP)
 - The client has Medicaid coverage at the time of the TCM visit.
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Other services the client or caregiver is receiving (check all that apply):

- Early Intervention (EI)
- Child Protective Services
- Developmental Disabilities
- Other TCM Program: _____

Caseworker name: _____ Phone: _____

Primary Care Home: _____ Phone: _____

CCO: _____ Phone: _____

(Documentation of service coordination throughout client's program participation is required for billing.)

The client's/caregiver's strengths that can be leveraged to support TCM plan:

Support System (current natural and community supports):

Client Name: _____ DOB: _____ Date of Service: _____

Assessment (check all identified needs):

- | | |
|---|--|
| <input type="checkbox"/> Advocating for self or child | <input type="checkbox"/> Medical specialty care or therapies |
| <input type="checkbox"/> Child care | <input type="checkbox"/> Mental health care |
| <input type="checkbox"/> Clothing and basic supplies | <input type="checkbox"/> PN/PP care |
| <input type="checkbox"/> Dental care | <input type="checkbox"/> Respite care |
| <input type="checkbox"/> Early education services | <input type="checkbox"/> Scheduling and keeping appointments |
| <input type="checkbox"/> Education, adult | <input type="checkbox"/> Substance use (ATOD) |
| <input type="checkbox"/> Food security | <input type="checkbox"/> Supplemental Security Income |
| <input type="checkbox"/> Health insurance/OHP | <input type="checkbox"/> Support system |
| <input type="checkbox"/> Housing stability | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Income stability | <input type="checkbox"/> Well-care visit/immunizations |
| <input type="checkbox"/> IPV resources | <input type="checkbox"/> WIC |
| <input type="checkbox"/> Legal aid | <input type="checkbox"/> Other: _____ |

The client/caregiver **does not need** or declines assistance accessing and/or utilizing needed services:

- | | |
|--|---|
| <input type="checkbox"/> Advocating effectively for self/child | <input type="checkbox"/> TCM Case Manager for another program is already in place and meeting needs (see above for details) |
| <input type="checkbox"/> Aware of services and how to access services | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Adequate social supports | |
| <input type="checkbox"/> History of adequate access and utilization of needed services | |

The client/caregiver **does need** assistance accessing and/or utilizing needed services:

- | | |
|---|---|
| <input type="checkbox"/> Requests assistance with paperwork because of language barrier, low literacy, etc. | <input type="checkbox"/> Instability of finances/housing/environment |
| <input type="checkbox"/> Requests assistance to secure basic needs (e.g., food, clothing, shelter) | <input type="checkbox"/> Limited awareness of preventive health care services |
| <input type="checkbox"/> Family health needs impacting the client's ability to access and utilize needed services | <input type="checkbox"/> Limited support system |
| <input type="checkbox"/> Requests assistance with health and human service resources available in the community | <input type="checkbox"/> Cultural/language barriers to services |
| <input type="checkbox"/> History of challenges accessing or utilizing needed services | <input type="checkbox"/> Limited client/caregiver literacy |
| <input type="checkbox"/> Requests assistance with advocacy | <input type="checkbox"/> Limited client/caregiver health literacy |
| | <input type="checkbox"/> Transportation difficulties |
| | <input type="checkbox"/> Other (specify): _____ |
| | <input type="checkbox"/> Other (specify): _____ |

RN Case Manager Signature: _____ Today's Date: _____

Client Name: _____ DOB: _____ Date of Service: _____