CaCoon Encounter/Data Form

Oregon Health Authority | FamilyNet

Client Primary Tab

Local ID	**LAST NAME**	**FIRST NAME**	Middle Name

DATE OF BIRTH	**GENDER** ☐ Female ☐ Male	☐ Confidential address / telephone?	☐ Update to address / telephone?

PHYSICAL ADDRESS TYPE
☐ Home ☐ Homeless ☐ Unknown

PHYSICAL ADDRESS	Apt. No.	**CITY, OREGON**	**ZIP**

MAILING ADDRESS (if different from physical address)	Apt. No.	**CITY, OREGON**	**ZIP**

MAY WE CONTACT YOU BY MAIL? ☐ Yes ☐ No

MAY WE CONTACT YOU BY PHONE? ☐ Yes ☐ No

PRIMARY PHONE TYPE	**PHONE NO.**	**PHONE OPTIONS**
☐ Cell Phone ☐ Home ☐ Message ☐ No Phone ☐ Unknown ☐ Work		☐ Both Voice & Text ☐ Text Only ☐ Voice Only

Alternate Phone Type	Phone No.	Phone Options
☐ Cell Phone ☐ Home ☐ Message ☐ No Phone ☐ Unknown ☐ Work		☐ Both Voice & Text ☐ Text Only ☐ Voice Only

Client E-mail

Guardian Last Name	Guardian First Name

Guardian Middle Name	Guardian Type

SPOKEN LANGUAGE

WRITTEN LANGUAGE

Alternate Format
☐ Audio Tape ☐ Braille ☐ Computer Disk
☐ Large Print ☐ Oral Presentation ☐ Other

RACE (Check all that apply.)
☐ American Indian/Alaskan Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian/Pacific Islander
☐ White

ETHNICITY
☐ No-Not Hispanic or Latino
☐ Yes-Hispanic or Latino

Medicaid No.*

Deceased Date

Client Info Tab

State ID	Income	Interval ☐ Week ☐ Bimonthl ☐ Month ☐ Annual	Family Size	Concurrent Program Enrollment ☐ Healthy Start ■ WIC ☐ NFP ■ Babies First ■ MCM ■ CaCoon

Insurance Status at Intake	SSI?	Billing Name - First	Billing Name - Last
☐ OHP Standard ☐ OHP Plus ☐ CAWEM ☐ Indian Health Service ☐ Other ☐ None	☐ Yes ☐ No		

CaCoon Case Tab

CASE START DATE	**CASE MANAGER**

Who referred client to this program?
☐ 1-WIC ☐ 2-Babies First! ☐ 3-CaCoon ☐ 4-OMC
☐ 5-MCM ☐ 6-PH Other ☐ 7-Healthy Start ☐ 8-SafeNe
☐ 9-NFP ☐ 11-Hospital ☐ 12-EI / ECSE ☐ 13-Self
☐ 79-PCP
☐ Other_____ (See codes)

Risk Factors
/ / / / / / /

Date Referred

CaCoon Tier
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 9

Does client have Early Intervention?
☐ Yes ☐ No

☐ Check if first birth

Birth Weight	Pounds / Ounces	OR	Grams	Birth Length	Inches	Cm	Gestational Age at Birth (weeks)

Data Notes

Last Name	First Name	Middle Name	Date of Birth

Visit Tab 1

VISIT DATE	**HOME VISITOR**

Weight Today	Pounds / Ounces	Grams	Length Today	Inches	Cm
		OR			**OR**

Head Circumference Today	Inches	Cm
		OR

Client's Immunization Status

- ☐ Complete or up-to-date (has all recommended shots)
- ☐ Delayed (has some of the recommended shots)
- ☐ None (has none of the recommended shots)
- ☐ Declined / Refused (declines or refuses recommended shots)

Breastfeeding started	Still breastfeeding	Age when formula or solids first introduced
☐ Yes ☐ No	☐ Yes ☐ No	☐ NA _____ weeks

Visit Tab 2

Issues / Outcomes — Interventions

Basic Needs (BN)

- ◯ A - Met
- ◯ B - Not met

Interventions:
☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Shelter
☐ 4 - Food ☐ 5 - $ Assistance ☐ 6 - Utilities
☐ 7 - Transportation

Nutrition (NU)

- ◯ A - Meets body requirements
- ◯ B - Less than body requirements
- ◯ C - More than body requirements

Interventions:
☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Nutritional Monitoring
☐ 4 - Breastfeeding Assistance ☐ 5 - Infant Cues

Nutrition Issues (NI)

- ◯ A - No nutrition issues
- ◯ B - Potential nutrition issues
- ◯ C - Actual nutrition issues

Interventions:
☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Nutritional Monitoring
☐ 4 - Breastfeeding Assistance ☐ 5 - Infant Cues ☐ 6 - Feeding Intervention
☐ 7 - Nutrition Care Plan

Injury (IN)

- ◯ A - Not at risk for injury
- ◯ B - At risk for injury

Interventions:
☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Safe Sleep
☐ 4 - Safety Checklist

Parenting (PA)

- ◯ A - Readiness for enhanced parenting
- ◯ B - At risk for impaired attachment
- ◯ C - Impaired parenting*

*Impaired parenting: the inability of the parent or primary caregiver to create, maintain, or regain an environment that promotes optimum growth and development of the child.

Interventions:
☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Promoting First Relationships©
☐ 4 - Attachment Promotion ☐ 5 - NCAST© ☐ 6 - H.O.M.E.©

Child Development (CD)

- ◯ A - Has age-appropriate pattern of development
- ◯ B - Appropriate development progression for condition
- ◯ C - At risk for delayed development
- ◯ D - Delayed development

Interventions:
☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Developmental Enhancement
☐ 4 - RDSI© ☐ 5 - IMS© ☐ 6 - ASQ®
☐ 7 - Vision Questionnaire ☐ 8 - Hearing Questionnaire ☐ 9 - Reflexes
☐ 10 - Pain ☐ 11 - H.O.M.E.© ☐ 12 - M-CHAT®

Well Child Care (WC)

- ◯ A - Has medical home*
- ◯ B - No medical home*

*Medical home: the client has a partnership with a primary care provider for health care, including prevention services and access to consultation after hours and on weekends.

Interventions:
☐ 1 - Individual Teaching ☐ 2 - Case Management

- ◯ A - Up to date on well child care (WU)
- ◯ B - Not up to date on well child care

Insurance (IS)

- ◯ A - OHP Standard
- ◯ B - OHP Plus
- ◯ C - CAWEM
- ◯ D - Indian Health Service
- ◯ E - Other
- ◯ F - None

Interventions:
☐ 1 - Individual Teaching ☐ 2 - Case Management

OHP Follow-Up Information (OF)

- ◯ A - Client refused referral
- ◯ B - OHP Pended
- ◯ C - OHP Denied

Continued on next page . . .

Last Name	First Name	Middle Name	Date of Birth

Issues / Outcomes | **Interventions**

Oral Health (OH)

- ◯ A - No identified dental caries
- ◯ B - At risk for dental caries
- ◯ C - Dental caries

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Oral Health Screening ☐ 4 - Fluoride Varnish Application

Oral Development (OD)

- ◯ A - No abnormal development
- ◯ B - At risk for abnormal development
- ◯ C - Abnormal development

☐ 1 - Individual Teaching ☐ 2 - Case Management

Access to Medical Care (AM)

- ◯ A - Yes
- ◯ B - No

Family has access to medical treatment appropriate for their child's condition.

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Health System Guidance

Community Resources (CR)

- ◯ A - Yes
- ◯ B - No

Family is knowledgeable about and is able to access community support and specialized services.

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Sustenance Support

Family Knowledge of Chronic Condition (FK)

- ◯ A - Yes
- ◯ B - No

Family is knowledgeable about their child's condition.

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - Normalization Promotion
☐ 4 - Parenting Promotion ☐ 5 - Teaching: Disease Process ☐ 6 - Child Health Assessment
☐ Family Assessment

Tobacco (TO)

- ◯ A - Yes
- ◯ B - No

Secondhand smoke exposure

☐ 1 - Individual Teaching ☐ 2 - Case Management ☐ 3 - 5As Clinical Guidelines

Household smoking rules (inside home at any time / on any occasion)

☐ No smoking allowed anywhere inside ☐ Smoking allowed in some rooms ☐ Smoking permitted anywhere inside

Visit Tab 3

Referrals Out (Check all that apply.)

12 - EI	☐ Referred
53 - Immunizations	☐ Referred
79 - Primary Provider	☐ Referred
90 - SSI	☐ Referred
94 - TANF	☐ Referred
1 - WIC	☐ Referred
Other _____ (See codes)	☐ Referred
Other _____ (See codes)	☐ Referred
Other _____ (See codes)	☐ Referred
Other _____ (See codes)	☐ Referred

Referral Follow-Up (Use this "Referral Follow-Up" field to record the outcome of referrals you made.)

12 - EI	☐ Getting Services	☐ Not eligible
53 - Immunizations	☐ Getting Services	☐ Not eligible
79 - Primary Provider	☐ Getting Services	☐ Not eligible
90 - SSI	☐ Getting Services	☐ Not eligible
94 - TANF	☐ Getting Services	☐ Not eligible
1 - WIC	☐ Getting Services	☐ Not eligible
Other _____ (See codes)	☐ Getting Services	☐ Not eligible
Other _____ (See codes)	☐ Getting Services	☐ Not eligible
Other _____ (See codes)	☐ Getting Services	☐ Not eligible
Other _____ (See codes)	☐ Getting Services	☐ Not eligible

Reason Case Closed *

- ☐ 01 - Declined services
- ☐ 02 - Unable to locate
- ☐ 03 - Family moved out of state
- ☐ 04 - Child deceased
- ☐ 05 - Child no longer age eligible
- ☐ 06 - Child moved out of county
- ☐ 07 - Child no longer needs services
- ☐ 08 - Passive decline
- ☐ 09 - Unable to visit/case load limitations
- ☐ 90 - Other

County Codes	Estimated Date of Next Visit	Date Case Closed *

Location * (Required for billing)

☐ 1 - Home / Field ☐ 2 - Hospital ☐ 3 - Health Department
☐ 4 - School ☐ 5 - Telephone ☐ 6 - Tertiary Care Evaluation
☐ 7 - Group Home / Shelter ☐ 8 - Client Not Home / Failed Visit ☐ 9 - Other

Time

☐ Submit TCM Claim *